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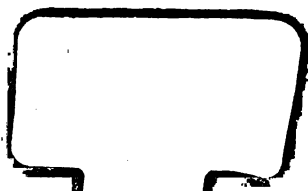
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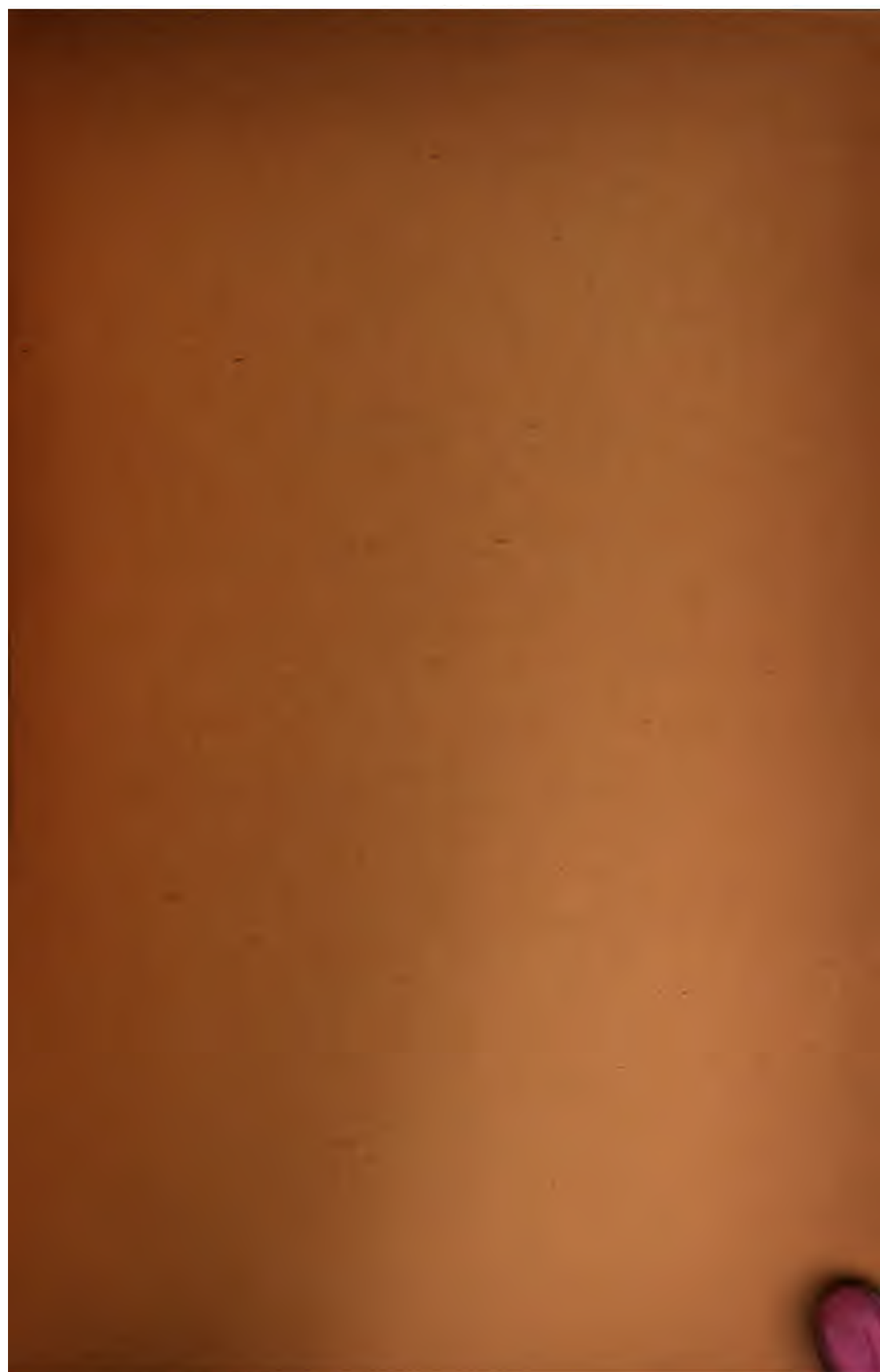


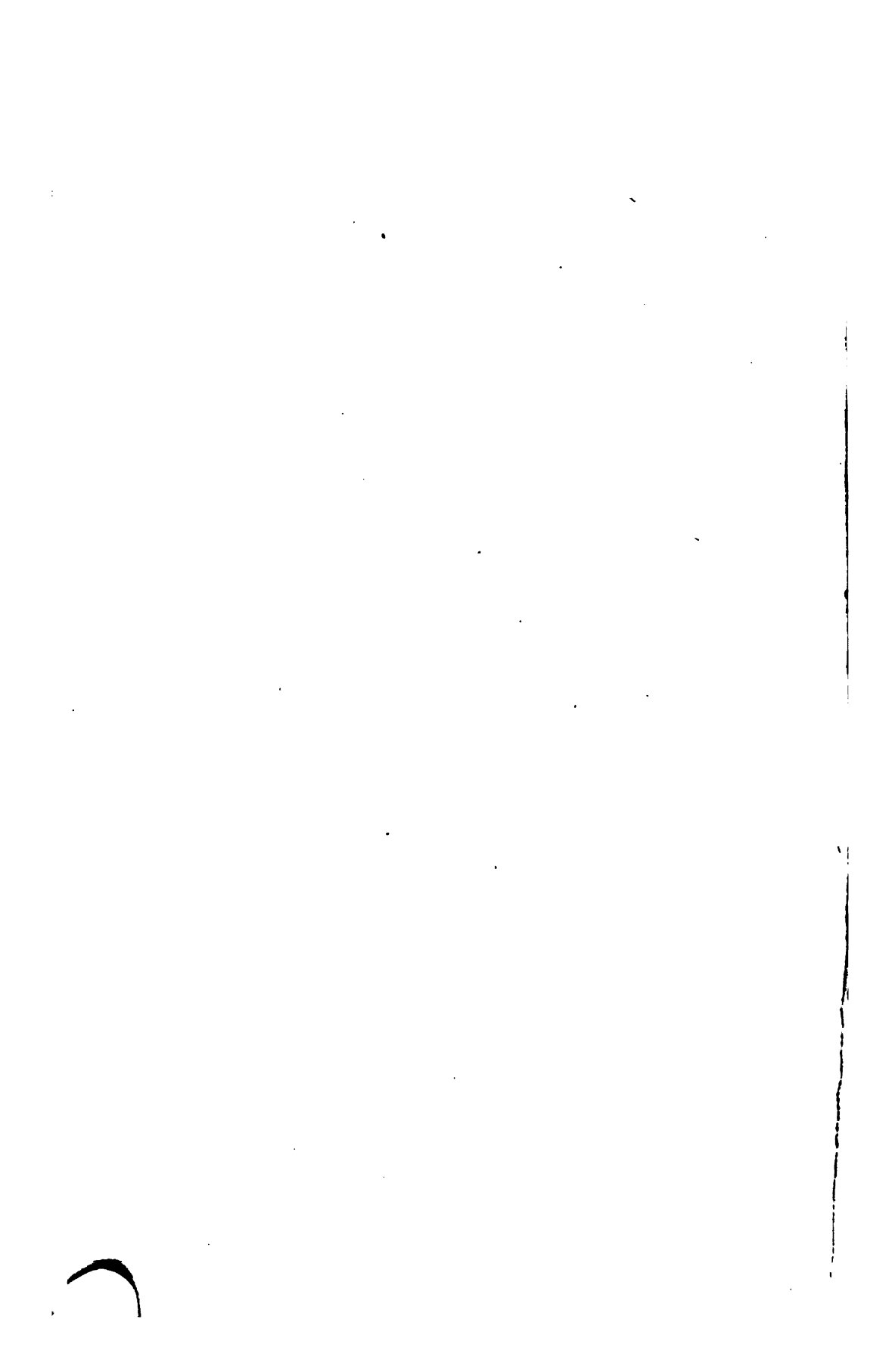


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Gynecology and Pedology

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EDITED BY  
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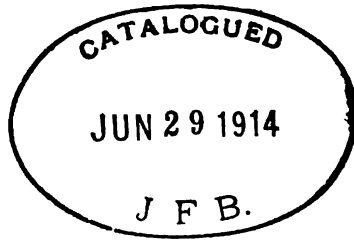
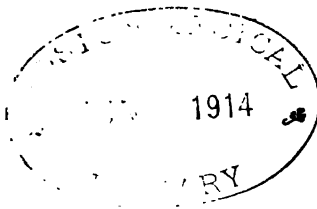
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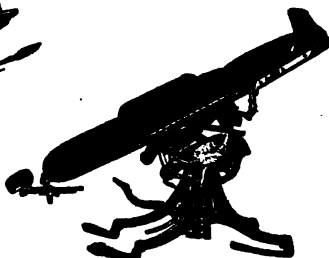


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Fig. I—Normal.

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Fig. IX—Chloroform Position.



Fig. XVII—Dorsal.

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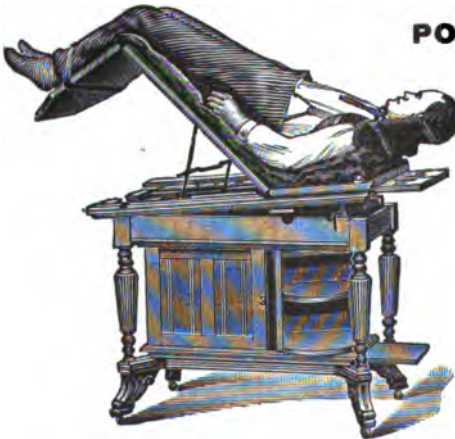
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No. 1.

JANUARY, 1893.

VOL. XV.

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## THE IMMEDIATE REPAIR OF INJURIES TO THE PELVIC FLOOR AT PARTURITION.

BY

PROFESSOR B. FRANK BETTS, M. D.,  
PHILADELPHIA.

---

**I**NJURIES to the pelvic floor resulting from parturition belong to two classes: to the first we assign the more or less extensive lacerations, and to the second those injuries arising from overdistention or sub-mucous tearing of the muscular tissues and aponeurotic membranes without external evidences of lacerations. There may be loss of tone and subsequent atrophy in these parts, with impairment of functions in both classes. As the attenuated condition is scarcely capable of being recognized until the patient has passed her lying-in period and the natural relations of the parts have been restored as far as possible by the lapse of time, no immediate operation is practicable, and this paper will deal only with such injuries as result from lacerations through some portion of the posterior vaginal wall or vulvar outlet, and attention will be mainly directed to such as involve the vagina at a point concealed from view within the vulvar orifice.

That such injuries are frequently overlooked or allowed to pass without attention at the time of parturition is proven by an examination of such patients as apply subsequently for treatment, and are found to have vaginal scars, which show that the parts have healed by granulation. As the ends of the torn muscles retract into the tissues at the time of injury, this process of healing does not secure a restoration of their functional action. That they remain permanently useless can be demonstrated to the satisfaction of the examiner if the finger is passed through the vulva and pressed against the floor of the pelvis somewhat firmly, so as to detect muscular contraction when the patient makes a voluntary effort to lift the pelvic floor toward the upper vaginal wall. There will be little or no movement felt in these cases, and if the injury is extensive the patient may even be able to detect her lack of ability to control these parts when her attention is directed to it.

Lacerations involving the muscular and aponeurotic tissues of the floor occur more frequently in the delivery of primiparæ, especially when forceps are required. In some cases we find upon one side of the central raphe a tear or cut extending longitudinally down the posterior vaginal wall, and in other cases the longitudinal rent may be in both sides of the posterior vaginal wall; but most frequently there are V-shaped rents extending diagonally across the posterior wall of the vagina from the central point back of the commissure on to the sides, as though the vulva had been pressed forward until the intact commissure was forced from the end of the vaginal canal, when the latter was distended to its fullest extent.

Indeed, this is what actually takes place in many cases, and at the time the vagina is distended this rent runs at right angles across its longitudinal axis, and if the external perineum is torn it occurs afterward, when the presenting part is passing the vulvar outlet, or, if it is a head-first case,

when the shoulder catches in the rent and plows its way through the perineum externally. When the tissues have contracted subsequent to the delivery of the child, we find in the vaginal orifice a mass of tissue overlooking the V-shaped rent below, like the bow of a miniature boat. This appearance is produced by the contraction and lifting up of the pelvic floor, where the muscles are intact, while the retraction of the ends of the torn muscles below, at the seat of injury, leaves a gap when the vulvar lips are separated. (See cut.)



It is important to bear these facts in mind when we come to repair the lacerations, for our object then is to restore the parts to their natural relations, and hence we must often apply sutures to the upper extremities of the V-shaped rent, from vaginal surface to vaginal surface, in such a manner as to draw down the ends of the retracted muscles into place before the tear through the posterior

commissure and external perineal body is attended to. When the anal sphincter is torn attention is first paid to *its* restoration, after which the operation is the same as in the other simple lacerations.

When there is no tear through the external or cutaneous surface, as sometimes occurs when there are tears in the vaginal wall only, or when the external portion of the rent is the only part approximated by sutures to the neglect of the other tears, we have a raw pocket left for the reception of the lochial discharges, which may soon become a source of septic infection, even though care is taken to douche the vaginal canal frequently.

Following in the wake of such injuries as have been mentioned we have, therefore, danger of septic infection, loss of function from the retraction of the liberated ends of the muscles, with consequent attenuation at this point of the recto-vaginal septum, so that rectocele is not slow to appear, and with the attendant subinvolution of the uterus, or lack of other pelvic discomforts.

One whose sense of touch is keen will be able to detect such vaginal rents and injuries as have been described immediately after parturition, and to repair them by the introduction of sutures without inspecting the parts, but others, not so fortunate, will overlook them or fail to repair them properly unless they are exposed to view, and all must wish to see them in order to do the best work, for in no other way can the necessary requirements of surgical cleanliness be secured before the introduction of the sutures. With these objects in view I have modified the Dawson-Sims speculum so that it will most effectually expose the parts, while it can at the same time be made self-retaining. It is introduced into the vagina so that the cleft blade is against the anterior vaginal wall, and an aluminum plate rests upon the abdominal wall above the mons veneris to secure it. By the use of this speculum the proper and natural relationship between the muscles and their aponeu-



rotic attachments can be secured, if care is taken to introduce the sutures in the manner to be described.

If the patient is delivered while lying across the foot of the bed, which is the best position by far when all things are taken into consideration, she need only be turned on to the back for the completion of the third stage of labor, the introduction of the speculum, and the inspection of the parts involved. If sutures are needed an anæsthetic may be administered if necessary and the parts cleansed, a tampon applied at a point in the canal which will prevent the discharges from flowing over the torn surfaces, which are then trimmed if shreddy, and a short curved needle with a loop of silk passed underneath the whole of the torn surface at the highest point in the vagina. With this loop a piece of fine silver wire may next be pulled into place. This process is repeated until all the sutures are introduced. The parts are again cleansed, the wire sutures shouldered and twisted accurately and cut moderately short, after which they are turned down flat upon the mucous membrane, and the patient placed properly in bed.

It may be said that such procedures appear formidable, but they are necessary in these cases in order to lessen the discomforts which follow childbirth, as it has been effected in the past; and the time has come when we all feel that we must bring to our obstetrical cases much of the skill and many of the appliances of the general surgeon, for less than surgical skill and surgical cleanliness endanger the immediate and remote welfare of the patient, and we should be as careful to close up and protect from extraneous influences all wounds and accessible injuries in the one case as in the other. It is a mistake not to be prepared for all such operations when we go to our obstetrical cases, and perhaps it may prove interesting even to the members of the American Obstetrical Society, standing as we do in the light that comes to us from the experience of the past, if a brief allusion is made to some of the accessories which

are likely to be required in the treatment of these cases, and which should be available in a convenient receptacle that can be brought into requisition at any time. In my obstetrical bag I have the following articles always ready, viz.:

A nail brush in a muslin bag, which latter can be as frequently washed and sterilized by ironing as is necessary.

One long forceps.

One short forceps, each in a separate muslin bag.

One syringe, also in sterilized bag.

Rubber sheeting 30"  $\times$  40" to be drawn about the waist of the patient by a cord when necessary, so that it may rest under the pelvis and answer the purpose of a Kelly pad.

One speculum.

One jar of gauze and cotton tampons.

One jar of iodoform gauze.

One small jar for needles and shot, in bicarbonate of soda solution.

One small jar for catgut.

One small jar for boracic acid.

One small jar for carbolized vaseline.

One 4-oz. bottle of A. C. E. Mixture.

One 4-oz. bottle of creolin.

One small bottle of fine silk ligatures.

One small bottle of bobbin.

One small bottle of silver wire.

One bottle containing catheter in carbolized solution, and the following instruments in a sterilized bag:

One scissors,

One Sims wire adjuster,

One needle holder,

Two tenacula,

One perineum needle.

ELECTRICAL TREATMENT OF UTERINE  
DISEASES.

BY

W. H. WHITE, M. D.,  
BOSTON.

IN examining various works upon electricity to find a date to fix the first application of it in uterine diseases there is a lamentable lack of information, most authors saying, "It is some years since I began," etc. Static electricity was used to cure cases of nervous diseases in the early part of the eighteenth century. In 1801 the galvanic form began to be used. In 1843 local faradization was first used in this country. In 1831 the galvanic puncture was used for the cure of aneurism; but not until 1847 do we find the constant current used in gynecology. In 1859 Tripièr presented a paper before the Academy of Sciences at Paris entitled, "Faradization in the Treatment of Engorgements and Displacements of the Uterus." In 1871 Cutter treated by galvano-puncture his first case of myomata. But the treatise published by Dr. Georges Apostoli in 1881 caused electrical treatment of uterine diseases to become more firmly established and made it a more exact science through the use of the milliamperemeter. The greater demand for electrical batteries has called out an improvement in their manufacture. This has resulted in a more even interruption and smoothness of current through the later styles of rheotome for the faradic current, and the late improvements in the form of a rheostat for the better government of the galvanic current. The kaolin rheostat of Professor Gärtner of Vienna and the carbon rheostat of J. C. Vetter & Co. of New York are the best.

Any physician who undertakes to use electricity in the treatment of gynecological diseases should have the best

and most approved apparatus possible. He should always bear in mind not to give too strong currents on first application. He should be certain of his diagnosis and learn the special idiosyncrasies of his patient, using the same care in the administration of electricity that one would employ in surgical cases of a like nature. In the treatment of uterine diseases by electricity one should look well into all the facts of the case to secure an accurate diagnosis, as this should govern him largely in the treatment of his patient. Acute cases will show themselves more sensitive to its influence than chronic, and any collection of pus, as in pyo-salpingitis, makes the current unbearable in most cases. Patients vary much in susceptibility, so one must carefully feel his way. For this reason the recorded statements of the number of milliampères used are by no means as valuable as one might be led to believe. Dr. Rockwell says, "A clear appreciation of the fact that the human system reacts to no drug with such varying susceptibility as to electricity is one of the first and most important lessons to be learned."

In speaking of the electrical treatment of uterine diseases I now give you that mode of procedure that has served me best in the greater number of cases.

In amenorrhœa look to the cause. If chlorotic use general faradization in connection with hygienic tonics, etc., thus toning up the general system. In robust patients use the galvanic current with the anode applied against the cervix and the cathode upon the abdomen, having a current of from five to twelve milliampères for five to ten minutes' duration. Local faradization is also much used.

In dysmenorrhœa, if caused by stenosis, the enlargement of the canal may be effected, as in a case of stricture of the male, by means of small-sized olive-pointed electrodes for the cathode, the anode being placed upon the abdomen in the form of a pad, and the galvanic current being from about ten to fifteen milliampères. In neuralgia the cup electrode

should be applied, as the anode serves best with a current of from ten to twenty-five milliampères.

In membranous dysmenorrhea use the abdominal part for the anode, and for the cathode the intra-uterine Apostoli electrode, passing the galvanic current over the endometrium in a manner that might be called curetting by electricity. The operation calls for care in its administration, the strength of the current usually being about ten milliampères.

In chronic endometritis I find the galvanic current a valuable adjunct, using the bipolar cervical electrode, or with intra-uterine electrode for the cathode, the anode being placed upon the abdomen in the shape of a pad, and a current strength of from fifteen to sixty milliampères.

I have already presented a paper on the subject of chronic metritis with the citing of cases, so a few words at the present time on this subject will suffice. In the lighter cases the faradic current may be used. I usually prefer the galvanic current with the intra-uterine electrode for the cathodal pole, and with the abdominal pad for the anode, with a current strength of from twenty to one hundred milliampères for the space of ten minutes. The hemorrhage is best controlled by the intra-uterine electrode as the anode.

It seems almost useless in these later days to speak of the necessity of using the milliampèremeter in uterine diseases.

In the treatment of displacements we have not had the success that has resulted in other uterine cases, probably owing to the lack of care after the application of electricity. Tripier's rules are those most often carried out, viz., for anteversion and ante flexion the use of the faradic current by an intra-uterine electrode with the other placed within the rectum; in retroversion and retroflexion the intra-uterine electrode as the anteversion with the other introduced into the bladder. This concentrates the current more than by the placing of the pad upon the abdomen, as is

often done. When in Vienna Dr. Kiry, the electrician of the Marie Theresa Hospital and assistant to Professor Rokittowsky, showed me a new instrument for action upon the ligaments supporting the uterus with which he hoped for better results in these cases and which is strongly recommended. I think that the use of tampons after treatment to support the uterus in correct position between the applications of electricity would ensure better results than have been achieved heretofore.

In chronic ovaritis the use of the galvanic current by means of the ball electrode placed against the ovary for the anode and the abdominal pad for the cathode has served me best with a current strength of from fifteen to forty milliamperes of ten minutes' duration.

In neuralgic pains the same treatment with current of from ten to thirty milliamperes.

---

## A CASE OF HYSTERO-EPILEPSY CURED BY REMOVAL OF THE APPENDAGES.

---

BY

PROFESSOR SHELDON LEAVITT, M. D.,  
CHICAGO.

---

**I** GATHER from late gynecological literature that the preponderance of evidence is against removal of the uterine appendages for hystero-epilepsy; but that the operation proves curative in certain cases is well known, the symptoms upon which to base our selections being the main question which remains to be solved. As bearing on this point the following narration may not prove uninteresting:

Mrs. D., æt. thirty, a woman of medium stature, poorly nourished, nervous and ambitious, gave birth to a child

some twenty-one months ago after a pregnancy in which there were œdema, albuminuria, and a labor complicated by convulsions. Her home was in Canada, and she was under the care of old school physicians. The getting up was slow, and some months after labor she began to have what she designated as sinking spells, followed after a number of months by real convulsions, in which she became totally unconscious. There was constant occipital headache, and the vision was at times greatly obscured. It appears that these symptoms were all referred by her physicians to nephritic origin, and her family was informed that a fatal termination could not long be deferred.

In September last she became possessed with an intense longing for her parents' home, and as this could not be appeased, her physicians finally acceded to her wishes and her father went down after her. A few days following her return I was called to make an examination of the case. I found her able to be about the house part of the time, but very nervous, with the staring expression so often observed in such cases frequently sweeping over her countenance. Her convulsive seizures sometimes occurred every day, occasionally twice a day, and were never deferred more than two weeks. They appeared to center more especially about the menstrual periods. She complained of some pain and a good deal of soreness in the right ovarian region. Upon making a careful digital exploration I found a cervical laceration on the left side, with considerable hard tissue, but without remarkable tenderness. Upon pressing the right ovary between the fingers she came near going into a convulsion, and the pain seemed to streak upward along the spine to the occiput. The left ovary was much less sensitive. That night she was extremely nervous and had one convulsion. Removal of the uterine appendages was recommended to her parents, and they readily consented thereto, but preferred first to secure the husband's consent. The latter came on im-

mediately, and though I had become well satisfied that the kidneys were not at fault, I had a thorough examination of the urine made by Professor Lyon, which resulted in the disclosure of pathological conditions.

Both husband and patient having consented to the operation, it was performed on October 7 last, at 11.30, in the presence of Drs. Honberger, Chislett, and Genius. The appendages on both sides were removed through an incision measuring exactly  $1\frac{3}{8}$  inch in length, and the wound was closed with three silk sutures. The operation occupied twenty-five minutes.

The right ovary was found to be twice as large as the left, and showed the fresh point of rupture, whence had escaped an ovule, menstruation having begun the very day of the operation.

Our experience with the patient after the operation proved the extreme good fortune of having so small a wound in the abdomen, for she rolled about in a reckless and totally ungovernable manner for the first forty-eight hours, insisting even upon getting into the prone position. Nothing but straps could have kept her supine.

Recovery was uncomplicated. The temperature did not go above  $99^{\circ}$ , nor the pulse above 80. The stitches were removed on the seventh day.

Some eight weeks after the laparotomy, finding that the uterine cervix was sensitive, and that touching it produced some of the old nervous symptoms, I decided to close the cervical rent, which I did in the usual manner. Two or three weeks subsequently the patient returned to her home in Canada. She has had no return of the convulsive seizures since the first operation, and the nervous sensations, together with the headache, are gradually fading; and her parents express themselves as highly delighted.



## SPECIALISTS IN INSANE ASYLUMS.

---

BYW. B. PERKINS,  
BOSTON, MASS.

---

THE subject which I have chosen for a little talk this evening is one full of interest to the general practitioner as well as the specialist, and it opens up a wide field for thought.

The relation which exists between the gynecologists and the alienists seem to be somewhat strained at present. It is caused by a disposition on the part of the gynecologists to render a little assistance to the alienists. The gynecologists have dared to insinuate that a woman when she enters an insane asylum does not leave her womanhood behind; that if she suffers from diseases of the genital organs the morbid conditions are not all spontaneously cured and do not all mysteriously disappear on entering an insane asylum. They have even gone so far as to suggest that some of the happy results they have seen follow operation on and treatment for the reproductive organs of women might occur inside an asylum if the patient were only permitted to have the same skill and treatment there. Not content with these hints and insinuations, the gynecologists actually claim that they have cured cases of insanity by replacing a retroverted uterus, removing the ovaries, and other gynecological manipulations.

But the alienists don't seem to appreciate the kindness that prompts all these proffers of assistance. At the meeting of the American Medical Association last May Dr. I. S. Stone of Washington discussed the subject, "Can the Gynecologists Aid the Alienists in Institutions for the Insane?" The doctor had systematically investigated the present

status of medical practice in the institutions for the insane in many of the States. His investigations developed the fact that the superintendents of asylums with but few creditable exceptions felt themselves competent to treat all phases of diseases of women, or, in fact, to be full fledged specialists in all departments. To his inquiry: can the gynecologists aid the alienists in institutions for the insane, he received largely negative replies. He drew the inference that asylum superintendents thought gynecologists meddlesome and bungling men who did more harm than good.

So far as he was able to determine, female diseases were seldom recognized, much less treated, by these superintendents. The doctor propounded this query: Why is it that insane women apparently do not have the same diseases that affect so many sane members of their sex? The discussion on this subject was very animated; and a large number of those who took part were of the opinion that a radical reform was needed in the management of our insane hospitals. Dr. Eastman of Indianapolis reported a case cured by him after the woman had been confined in an asylum for a year and discharged hopelessly insane. The doctor found one of the fallopian tubes bent sharply on itself and bound down by a peritonitic adhesion. He removed the appendages and the insanity was cured.

Dr. Reed, of Cincinnati, who had given the subject much serious attention for a number of years, said: The claim that the medical superintendent, who is generally a housekeeper, a gardener, a jailer, is at the same time competent to treat diseases of the eye and ear, of the lungs, pelvis, and every other organ, was preposterous. He said he was satisfied of the sound scientific basis for reform which would involve the appointment not only of gynecologists but of specialists in all other departments as staff officers to asylums. I will refrain from commenting upon the thoughts and opinions expressed by these physicians until I have given you the comments of a well-known and able alienist on this very

question. In the fall of 1889 a committee was appointed by the London County Council to inquire into the desirability of a hospital for the insane having only one resident medical officer of asylum experience, who was to be senior resident medical officer. The medical staff was to consist of a certain number of visiting physicians to include a pathologist, a surgeon, an ophthalmic surgeon, an aural surgeon, a laryngologist, and a gynecologist. Dr. Weatherly, an alienist of some note, and physician to an insane asylum in Bath, England, in commenting upon the report of that committee, said he believed their recommendations were based on the false impression that every symptom of any case of mental disease means some related disease of the brain, or that there was nothing psychical but everything physical in all mental derangements.

He says we fully recognize the fact that great results have already been attained by physical examination of brain function; we metaphorically applaud to the echo the work done in localizing brain areas connected with the special senses, but dare we hope that mental moods and distinct manifestations of the working of the mind can ever be so localized? He quotes Dr. Yellowlee in these words: "Has the most enthusiastic physiologist ever dreamed that he could localize in any spot of brain an all pervading emotion like joy, or fear, or hope, or love?" Now, the doctor speaks to the point when he says that nowadays the mass of clerical work devolving upon asylum superintendents is far too great to admit of their working at individual cases as they would desire. It has long been recognized by all interested in psychological medicine, and they do not require *outsiders* to stimulate them in their endeavors to do all that is possible for the treatment and mitigation of this terrible scourge, insanity.

The term *outsiders* has a peculiar significance as you look into the question. You will notice that the doctor has not met the question at all, but clouded it by mystical

allusions to what is as yet buried in the great unknown. The fact that no one can yet localize a mental mood or an all pervading emotion in any spot of brain is no evidence that they may not be localized. It is well known by gynecologists that certain diseases and injuries to the genital organs of women have been the cause of many moods and emotions. It may be that no emotion can even be exactly localized.

I don't know that it is necessary to go on such a chase. Emotions may be caused by the disturbance of a number of functions, or a number of physical organs (?), and if the alienists cannot locate any certain emotion in the brain it is all the more reason why they should labor together with other specialists to investigate in other regions.

The reason psychologists have made so little progress in the last half century is because they have been laboring in an air of mystery. They commence at the unknown and try to work down to the known. They should commence at the known and work up to the unknown; then the mystery will disappear. In regard to specialists in insane hospitals I will say that I do not think the plan suggested by the committee of the London County Council, and also by Dr. Reed of Cincinnati, practicable or wise, at least to commence with.

A much better way would be to require that superintendents of insane hospitals have not less than ten years of *successful* general practice. The position of first assistant physician is quite as important as the superintendent, and he should have ten years of successful general practice and three years of special training in gynecology with special relation to insanity; these qualifications should be required before one is eligible to the two highest positions in an asylum for the insane. The superintendents, of course, should have had several years' experience in a subordinate capacity. Physicians in insane asylums are rarely men of any considerable experience in general practice. They do

not have, as a rule, broad enough views of the human organism, either in health or disease. Many of them become very narrow and come to look upon almost everyone as insane. I believe out of the present agitation of this subject will come a great reform in the management of insane hospitals.

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A CASE OF SUPPOSED PREGNANCY CURED BY  
CROCUS SATIVA.

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BY

PROFESSOR ALBERT WHEELER, M. D.,  
SAN FRANCISCO.

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SOME three months ago I was called upon to decide in a case of supposed pregnancy by a woman whose husband had been from home for several months. She had received a letter informing her that he would be home in a few weeks. This intelligence, instead of bringing joy, filled her mind with great perturbation; she freely acknowledged her impropriety, and desired above all things to be satisfied in regard to her situation. She had not missed her menses a single time, had experienced no morning sickness, had no longing for nor loathing of food, no change in the mammæ or areola—in fact, there was not present one sign or symptom of pregnancy; but she insisted that she plainly felt the movements of the child, though she supposed herself to be but three months pregnant. I told her it was all imagination, that she was not pregnant, and advised her to go home and “sin no more.” She appeared to be satisfied and left. In a week from that time she presented herself again, with conscience “ill at ease,” and was more positive than ever that she had felt “*something living jumping about in her abdomen*” several times since

her last interview, and insisted on being examined. She was under the impression that the knowledge thus obtained would be conclusive and would relieve her mind of all further anxiety and doubt. With a view of satisfying her I complied with her request, and then renewed my assurance that she was as free from pregnancy as a child. Receiving this as a finality and a vial of crocus sativa 30x, she left. I heard nothing from her until yesterday. The third dose of crocus cured her.

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### THE BLIGHTED OVUM.

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BY

PROFESSOR P. J. B. WAIT,  
NEW YORK.

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LACK of definite knowledge in relation to the blighted ovum has led to confusion in our science; and worse, to superstitions which still shadow this pathological condition of a strictly physiological product. The term "mole," applied to blighted ova, has no doubt been a reason for cloudiness upon the subject in the minds of many who would have had no difficulty in understanding the full force of the term blighted ovum. I have heard a discussion upon "moles" when it was apparent that neither the physiology nor pathology of the disease was understood by parties taking part in the discussion. The idea which formerly prevailed that moles might or might not result from impregnation was thoroughly misleading, and offered a satisfactory excuse for much ignorance upon the subject. At present, however, there appears to be no difference of opinion. The "mole," no matter what form it assumes, is a product of conception, but through disease or accident the development of a vivified ovum has been arrested and changes

greater or less have taken place, thus producing a blighted ovum. This is equally true whether the blight assumes the form of the so-called carneous, the hydatid form, or the sanguineous mole, and since the nomenclature of a science should aim to make every point as clear as possible, it would seem to be better to call all of these morbid varieties "blighted ova," as they really are, simply defining the peculiarities of each.

The laity have a term for all morbid uterine growths which are thrown off by active uterine contractions, "false conception," which to them is all comprehensive and for which, no doubt, physicians are responsible. This term may mean something or nothing, as it is applied to any abortive attempt of the uterus where no fetus is discovered; but every obstetrician is aware how easy it may be, without the exercise of the greatest vigilance on the part of the attendant, for the ovum to escape detection. The so-called false conceptions have probably in a large majority of cases been normal so far as they progressed. I have not succeeded in finding data as to the frequency with which blighted ova occur, these phenomena being included under the general head, "abortions." There seems to be no good reason why children born at term, with parts of the body wanting, or with limbs clubbed or otherwise deformed, or with the elements of the body unnaturally distributed, and which are classed under the general term "monsters," may not reasonably be referred to blighted ova. Leavitt, who has an unusually interesting discussion upon "Intra-uterine Amputations" and "Monstrosities," remarks of the former: "A certain number of these amputations probably result from coiling the cord about the extremities; and another of the most common causes is the constriction of fibrous bands or folds of the amnion. [Are not these bands due to blight?—P. J. B. W.] *But in many instances none of these causes have been at work and hence their ætiology is shrouded in obscurity.*"

Is it not entirely reasonable that a blight which in one

case is capable of destroying all traces of the embryo may in another case be only sufficient to destroy portions of the embryo, thus rendering the fetus deficient in arms or legs or head or brain, or to cause the elements of the body to be unnaturally distributed? Blighted ova of the hydatid form or of the fleshy variety have not only lost all traces of the embryo, but are as far removed from the form or appearance of the healthy ovum as is the acephalous birth from a well-developed fetus. If the hypothesis that all imperfectly developed fetuses can be rationally accounted for upon the theory that they are the result of blighted ova, their ætiology will no longer be "shrouded in obscurity," and our science will be stripped of much that is confusing if not altogether misleading.

For a number of years I have been studying to inform myself upon the causes which produce blighted ova, reading upon the subject all which has fallen in my way, and striving to bring light out of darkness, as occasionally blights have fallen under my own observation. The duty of the physician being always to find a cause for any untoward condition which may arise in his patient, I have tried to cipher as best I might the causes for these unwelcome and uncanny developments, and if I have succeeded in satisfying my patients, frankness to the members of this bureau compels me to confess that the conclusions have not always been fully satisfactory to myself. Setting aside all the well-known and universally recognized causes for diseased conditions of the ovum (chiefest of all being syphilis), and then why a healthy woman, with an equally healthy husband, after bearing a number of healthy children, should, without any known change in condition, suddenly abort with a blighted ovum is very surprising. Cases of this kind which have fallen under my observation in private practice have not in any instance given history of specific infection, and I do not recall a case where there have not been healthy children born either before, or both before



and after the blighted ovum presented itself. The blighted ovum of the fleshy variety and the one known as the sanguineous mole seem to be only different degrees of the same condition, although authors make a distinction, referring to the former as the "carneous mole," and to the latter as the "mole of abortion." Both are clearly products of conception, and they differ not very materially in appearance. The semblance of the ovum is more nearly obliterated in the carneous variety, leaving a fleshy mass not unlike the substance of the placenta, while in the sanguineous or "mole of abortion" portions of the chorionic villi still remain, but the walls have acquired a thick, fleshy condition which has so trespassed upon the cavity of the amnion as to nearly obliterate it. The hydatid form variety differs widely from the carneous and sanguineous. In the hydatid form the changes in the chorionic villi are reversed, it becoming more or less hypertrophied instead of atrophied, and possibly disappearing altogether. All of the villousities increase in size in the hydatid form, and the tufts assume the peculiar appearance of clusters of vesicles. The walls of the ovum partake of the general hypertrophy, and with their cover of vesicular tufts present a remarkable appearance, which only a few practitioners ever have the opportunity of seeing. The embryo is destroyed as in other varieties of blight.

All varieties of blighted ova are due to disease of the ovum in very early pregnancy. It was the fleshy blight which early writers claimed were developed independently of impregnation, unless remnants of chorionic villi were present, when impregnation was not disputed. We read that these blighted ova may be retained *in utero* for a number of months, and acquire sometimes an enormous size, but to the best of my knowledge those which I have met have varied from nine to twelve weeks in development, the largest one not exceeding one-third the volume of my closed fist. My first case, which occurred in early practice,

puzzled me very much. The patient, a mother of three children, aborted at about the eighth or ninth week with two blighted ova of the fleshy variety. There were no signs of chorionic villi, and only a smooth, hollow depression, which answered to the center of the amnion; but no suggestion of an embryo in either. These specimens were submitted to a more experienced physician, and I was instructed that, it having been a twin pregnancy, the patient was not able to carry the dual product, and so had aborted. Later a study for myself convinced me that a different reason must have existed. The patient afterward had several children born (one birth being twins) without a recurrence of the trouble.

Another case some time later was almost entirely similar to the first, there being two fleshy blights, in size and appearance like the one already described, but I was not even then prepared to adopt the twin suggestion of my former adviser. This patient was the mother of several children, and later had others with no other blights so long as she remained under my observation. Of twin blights these are all which I have met, but of single ones there have been a number, some of the fleshy and others of the sanguineous variety.

In but one case of mine has a blighted ovum occurred in a primiparous woman, and upon the advent of a second pregnancy I felt anxious lest the former experience might be repeated, but it was not—a well-developed child, perfect in all respects, being born at full term. Blighted ova, which our authors call “moles of abortion,” usually present irregular outlines, a part having the chorionic villi, but not the transparency of the healthy ovum, while the remainder are shriveled and leathery; or again, they are normally shaped and sized, with chorionic villi apparently normal; but holding them between the eye and the light reveals the thickened texture of the walls, while cutting them open will alone show to what extent the fleshiness of the walls has de-

veloped and whether any sign of an embryo be present, it being usually wanting. One symptom which I have found common to all of my cases of blighted ova has been an unusually nervous excitability of the patient during her pregnancy, amounting in one case almost to mental alienation; but whether this could be set down as positively predicting a blighted ovum it would hardly be safe to assert. In no instance have I met the excessive flowing which we read of as taking place when these blights are thrown off, and in all cases recovery has been rapid and satisfactory.

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## PROPHYLACTIC MEDICINE IN GYNECOLOGY.

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BY

HENRY C. ALDRICH, M. D.

MINNEAPOLIS, MINN.

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I SHALL open my paper by parodying a familiar quotation: Our light *is* so shining, that men seeing our good works follow them. Witness the very able article by C. B. Deming, M. D., of New York, in the *Journal of the American Medical Association* for January 16, 1892, in favor of small dosage and palatable medicines, claiming that homeopathy had done more to injure the *regular* (?) school of medicine than all the rest of the different quackeries put together. Time compels forces to bend, and *some* who were formerly the most ardent disciples of the scalpel are beginning to cry aloud for a *new* and *special* pathology.

Dr. F. B. Robinson of Chicago, an allopathic physician, a strong adherent, a fervent admirer, and a pupil of Mr. Lawson Tait, comes to the front and says, *we* [the allopaths] are doing too many laparotomies; organs are *generally* removed for some pathological cause; the ovary should come

under the ordinary rule. It is time for some special pathology to come to our aid, etc., etc.

With all due respect to those gentlemen who are calling for a *new* and *special* pathology, I should like to tell them that that is *not* what they want. Pathology is that part of our science which has for its object the knowledge of disease, either general or special. What they do need is to overcome that unfortunate tendency prevailing among them of sneering at therapeutics, and to apply curative remedies in place of the knife. These devotees of the scalpel will cite any number of recoveries to prove to you that operative treatment was the only thing to be done; recoveries do not prove *that* by any manner of means. This mania for mechanical interference which has swept the country from end to end during the last two decades shows a decided retrogression, a backward step among those men who have allowed themselves to be carried along in its wake.

In a recent number of the *American Journal of Obstetrics*, the "Transactions of the Woman's Hospital of New York" were published, and Dr. Dudley is credited with advising the graduates to give more attention to the peritoneal side, if they wished to make a gynecological success.

Upon reading that, this thought occurred to me: Are such fanatics entitled to bear the honorable cognomen, "Doctor of Medicine"? For certainly the purpose for which medicine, as an art, exists is the eradication of disease. The natural condition of man has not changed since the time when Hahnemann broke through the bonds of ignorance and prejudice, and applied the tests of observation and reason to matters within the medical realm.

In the "Organon" as well as other writings of Hahnemann we find ample proof that he not only sought to cure disease, but to annihilate any tendency thereto.

You are all familiar with his experiments, the opposition and superstition he had to fight against, and the gradual

development of a new *materia medica* and system of therapeutics as a result.

Now when more of our allopathic *confrères* realize that the word therapeutics means the art of restoring and the discovery and application of remedies for diseases, then will they have found the remedy for which they are vainly inquiring of each other to-day. The gentler ways are the best and mightiest; this is the lesson nature and homeopathy teaches. "Nature tells us that through channels too small to see, she is sending into the tree tops high above our heads floods of water that make the noisiest pumps seem feeble, and so we gain luxuriant growth and fruit."

Homeopathy teaches us that it too works through means which are infinitesimal, and that the physician has but to cure speedily, gently, and permanently; the results are plainly perceptible. We have ever and always enjoyed a rich fruitage and are attaining a most luxuriant growth; the records of both hospital and private practice prove the one; statistics and the lamentations of the old school physicians prove the other.

I said that when the adherents of allopathy understood the value of a system of therapeutics they would discover the remedy for which they are now vainly seeking; they will then find themselves in readiness for the next step, and will know that medicine is justly divided into "prophylactic, or the art of preserving health," and "therapeutic, or the art of restoring health."

As a prophylactic, homeopathy stands alone. In this field we have carried off the most enduring honors; thousands that are the victims of hereditary diseases to-day might be in possession of good health could they but have enjoyed systematic homeopathic treatment during infancy and childhood. Dr. August Korndoerfer says "that a careful and extended survey of the results in families who for twenty and more years have been continuously under homeopathic treatment affords abundant evidence of this

fact ; the percentage of developed disease of tubercular type is extremely small, quite too small to be attributed to mere chance. This is just as true of other forms of hereditary disease as of tuberculosis. A law which is true must also be universal in its sphere ; results prove this to be the case.

Some of our leading men aver that women who have had genuine homeopathic care from infancy are not liable to the ordinary diseases of their sex. B. Frank Betts, M. D., says : " We effect more good in many instances than we are aware of at the time of prescribing, and prevent the development of some of the most formidable diseases to which the reproductive organs become liable after puberty." He reports over two hundred cases suffering from tumors, and in no instance were they habitually under homeopathic treatment during early life.

I made inquiry among some of the oldest practitioners abroad as well as in this country in reference to cases suffering from uterine or ovarian diseases or tumors, after being treated during infancy and childhood by homeopathy, and again the percentage is quite too small to be attributed to chance.

The fact is established beyond cavil that morphological products are the outgrowth of cell insubordination, a something that has gone beyond the control of the nervous system ; then it is only in accordance with reason to believe that systematic treatment of these while in an embryonic state will give us the most forcible results. If we deny this we deny in a large measure homeopathy itself.

The friends who kindly reported cases for my benefit are gentlemen of large experience. My own observations, both at home and abroad, have strengthened my already firm belief in homeopathy as a prophylactic. Among some two hundred cases of abdominal tumors which have come under my observation, not one had been treated at any time in early life homeopathically ; the cases coming under our notice in our own hospitals and dispensaries are largely

foreigners, and it goes without saying that their treatment has always been of allopathy the most allopathic. If you will give the matter a moment's consideration I believe you will not find among your patients one suffering from any morphological product, unless it be some poor creature whose strength and substance have been wantonly wasted by old school treatment.

I think it was Oliver Wendell Holmes who said: "A boy's education should begin one hundred years before his birth." How much more important is it, then, that hereditary physical evils should be corrected by treatment, through the mother, of the unborn child. Where such opportunities are offered us, I need not say that health will reign supreme and homeopathy prove its prophylactic power.

This is the direction in which our greatest successes are to be made. As gynecologists we must look into the early history of parents, and grandparents even, and by the application of indicated remedies annihilate hereditary constitutional diseases. They say that sin and wickedness come through disease: then, as hereditary ailments are stamped out by systematic constitutional treatment, it remains as a matter of course that the millenium is to be brought about by the practitioners of the new school, and yet another star added to the already brilliant crown of Hahnemann.

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—*Natrum sulph.* is unquestionably a valuable remedy in asthma in children. I have entirely cured by means of this remedy several cases that had always had an attack from any change of weather or gastric disturbance. Almost invariably I found a history of eczema (tinea capitis) in these cases, which would guide to some other of the anti-psoric remedies when the action of this seemed to be exhausted.—Dr. Boericke in *Cal. Hom.*

## THE CARE OF THE MOTHER AFTER LABOR.

BY

A. A. BACKUS, M. D.,

ADRIAN, MICH.

IN thinking upon labor and its sequelæ we are too apt to consider its physiological features, and leave to nature what, in this artificial age, should be aided by science.

True as it is that labor is a physiological act, it would seem from the ills which so often follow that pathology was its result.

We need not go to specialists to learn the weaknesses and troubles dating from first confinement.

Nor is this to be wondered at. We are taught much about presentations, the use of instruments, the care during accouchement: the *after care* is so neglected that a physician thinks his duties completed after the third or fifth day.

A ruptured perineum or lacerated cervix seems to be the only object of interest to the average obstetrician; and it is not the torn perineum nor the lacerated cervix which places the greatest number of patients upon the gynecologist's table.

To consider the growth of the fetus and the days of its gestation does not belong to this paper; but to consider the changes which have taken place in the uterus, ligaments, and abdomen at the end of these days does.

Here we have an organ in its virgin state measuring  $2\frac{1}{2}$  inches in length, and  $1\frac{1}{2}$  or 2 inches in width enlarged until its measurements are twelve inches in length and nine inches in width.

Krause tells us the uterine cavity is increased by pregnancy 519 times.



Levret says the virgin uterus presents a surface of sixteen square inches, and the pregnant uterus at term, 339 square inches.

It takes nine months to bring these changes about, and it takes more years than a woman ever lives to return them to their original condition. When a woman arises after confinement much of the prop is taken away from the uterus, which in its enlarged condition needs it more than ever it did in its virgin state. The relaxed abdominal walls, the stretched ligaments, the enlarged vagina, leave that unfortunate organ, the uterus, a veritable tramp without visible means of support; and instead of it being the wonder that so many women suffer weakness, it is a marvel that any woman (with the usual lack of care and attention after childbirth) ever passes the ordeal, and regains a fair amount of health.

Thirty days is the time usually allotted for the lying-in woman, and then without any very unusual care she is expected to take up the duties of domestic life as though nothing had happened. Indeed, you are fortunate in your patient if she can be persuaded to rest that length of time, and if you insist upon it you will be looked upon as a crank. So the after care of the mother is more a matter of theory than practice.

Yet in the few cases where the theory has been followed the results are such as to encourage the trial, even at the expense of being called a crank.

In the first place, no woman should be allowed to walk about for the first three months without a good elastic abdominal support. It is not only an aid in holding the organs in place, but has cosmetic effects as well, and with this argument a patient will yield when the thought of health would have no weight.

The hot douche should be a part of the post-puerperal care; that, with the addition of tannin and glycerin tampons, used every other night, greatly assists in restoring

tone to the vaginal walls, as well as aiding the involution of the uterus.

The breasts should have their full amount of attention, not only when the child begins to nurse, but when weaned. It is the writer's experience that very many diseases of these glands are first established at this period, and as much care should be given cessation of lactation as to see that the flow starts properly.

In the few cases where I have been permitted to try it the wearing of cool, close-fitting muslin slings, secured over the shoulders and beneath the arms and fastened at the back, have been not only a great comfort to the patient, but have kept the breasts in a firm, elastic condition, such as I have never seen except in the virgin breasts.

As a rule, the care of the mother is neglected in the attention given the child, and frequently the care given the infant is just the sort of care it does not need. Bouncings and peppermint, bandages and skirts, until the babe seems a chaos of embroideries and a reservoir of gas.

Drugging infants is one of the most common customs of the professional nurse, and one most perplexing to overcome. Castor oil and paragoric are daily administered for the cure of tight bandages and puncturing pins.

A few days ago I was called to see an infant who had been about twenty-one days in this "work-a-day world." Upon asking the trouble was informed that the baby was so cross they could do nothing with him; had given castor oil and soothing syrup, but still it cried.

I picked up the poor little morsel of humanity, loosened the bands about its waist, when presto! change! the cry ceased and has scarcely been heard from since.

When a child is nursing the mother it is very seldom we get stomach troubles if the mother is careful of her diet; but when nursing the bottle it is very hard at times to find a suitable food. Cow's milk, properly diluted, is, in the

majority of cases, the best; after this goat's milk; in fact, the milk from the goat will in some cases prove better than any other food, even the mother's own.

In that too common trouble where the infant vomits the curdled milk, the best preparation I have yet used is Philip's milk of magnesia. Half a teaspoonful mixed in the milk has never failed to correct the trouble.

There are many good foods in the market, but different children require different preparations, so the best thing to do, I find, is to study and learn that which is best for the individual, sparing no pains in so doing, for the health of the child rests upon the welfare of the babe.

The most difficult thing in the world, next to reforming the dress of the mother, is to reform that of the infant. To dispose of the supernumerary skirts, bandages, and pins is the one thing the average mother will not do. But fortunately there are a few exceptions, and it is from these we learn what can be done toward bringing the babe through its early months in comfort to itself and friends. Hygiene is the principal study to use in the affairs of babyhood. Drugs play a small part here. A maximum of the laws of health with a minimum of medicine is the best prescription I can give in regard to the care of both mother and child.

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—*Kali phos.*—One undoubted case of somnambulism was readily and permanently cured by a few doses of the sixth trituration of this remedy. It deserves trial in night terrors of children as well as in morbid fears and over-sensitiveness, and in the whining, fretfulness, and sleeplessness of nervous children.—Dr. Boericke in *Cal. Hom.*

—*Kali sulph.*—In the later stages of catarrhal cough, when there is much loose phlegm, great rattling of mucus in chest, this remedy is to be remembered with antim. tart., ipecac, etc. Its symptoms are apt to be worse in the heated room.—Dr. Boericke in *Cal. Hom.*

## THE RADICAL CURE OF UTERINE DISPLACEMENTS.

BY

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THE treatment of chronic or long standing uterine displacements by internal medication cannot, from a rational or common sense standpoint, be expected to do more than relieve some of the nerve complaints or subjective symptoms by which the dislocation makes itself known; and the treatment by mechanical support or pessaries has been so generally unsatisfactory that it is fast becoming a thing of the past, because no *permanent* benefit is derived in the majority of cases. Yet to ignore such conditions or class them as incurable is as unreasonable and unscientific as to so consider dislocations of joints or fractures of bones. Electricity in skillful hands and massage when applied in a systematic and thorough manner have proved effective means of cure in many cases; but after all non-surgical means and measures have been faithfully tried there still remains a considerable number of cases which are not cured and in which the dislocation is a source of great discomfort, if not actual danger, to the patients. It is for this intractable class of cases that surgical treatment is especially advocated, though it may also be with good reason substituted for some of the slower, more uncertain, and quite as painful measures in many less desperate cases.

Until a comparatively recent date all efforts at correction of uterine malpositions were directed to the vagina, *i. e.*, creating a support upon which the cervix should rest, by repairing the perineum, narrowing the vagina, or making a ledge or pocket to receive and support

the cervix ; but in the last few years it has come gradually to be recognized that the attachments of the fundus uteri to the brim of the pelvis were just as essential to its maintenance in a normal position as those by which the cervix is held in proper place and relation—that no matter how well and how securely the latter might be fixed, if the fundus is allowed to fall backward so as to bring the axis of the uterus on the same plane as that of the vagina, it will surely, by its own weight, re-enforced by external pressure and the superincumbent weight of clothing, gradually force its way, like a wedge, through any resistance in the soft parts below : whereas if the fundus be maintained in its normal relative position, and if the uterine axis be at right angles to that of the vagina or nearly so, prolapse is not likely to occur nor vaginal props be found necessary.

Various methods of securing this position of the fundus have been proposed and applied, but none so simple, so free from danger, or so satisfactory in results as the shortening of the round ligaments. We cannot expect to create a *better* condition than that which *naturally* exists in a normal state ; and this more than any other method restores the tension to the round and broad ligaments, which had been lost, and without which the fundus uteri can find no support. To fasten the fundus to the abdominal wall, as some operations require, creates an unnatural condition and relation of parts, which is not only apt to cause much discomfort ever after, but is not without danger, especially if pregnancy should subsequently occur, while the operation itself is vastly more dangerous and painful to the patient.

I shall not attempt at this time to consider the treatment of all forms of uterine displacement, and indeed I shall confine myself to the very limited class of backward dislocations, either versions or flexions, with or without prolapsus, which are of a chronic character, and not complicated by any considerable adhesions. But even with these narrow

limitations there are many, very many cases which defy all medicinal and mechanical efforts for their cure. Massage and electricity both accomplish much in some of these cases when applied under the most favorable conditions and by skilled operators; but neither of these is to be commanded in many instances, and unskillful application or unfavorable conditions, or both combined, are much more common, and consequently comparatively few cases are thus satisfactorily treated or cured. It is in just this class of cases, and this only, that the operations for shortening the round ligaments will almost invariably effect a radical cure; and being so simple, so rational, so free from danger or pain, it seems to me that it should be applied much more frequently than it has yet been. For several years I have maintained its inherent merit and have operated upon a considerable number of cases, and by different methods; and while not a case has failed to find permanent relief from the operation, whether done by Alexander's method or its modifications, or by Tait's, Wylie's, or Polk's intra-peritoneal methods, I feel that the most certain, safe, and easy operation is the one which has been termed the direct method, and described by Edebohls of New York at the International Congress a year ago. This operation, which alone I shall briefly describe, consists in simply cutting down over the inguinal canal on either side through the skin and fascia. The external abdominal ring being thus exposed, the aponeurosis which forms the anterior wall of the canal is slit up to the internal ring, where the round ligament is easily distinguished and drawn out enough to remove the slack which the long continued dislocation has produced, and until the fundus, which is raised and held up by an assistant, finds support in its proper location—from the cords or ligaments on either side. As the ligament is drawn out, the peritoneal reflection which surrounds it is pulled back, and then the ligament is stitched with catgut to the wall of the canal and the tissues closed over it. The

abdominal cavity is not opened, and we have made only a small wound in the abdominal wall, which should always heal by first intention. The operation is rarely attended with any considerable rise in temperature or much pain, and it *is* a radical cure for these cases. I know we are charged with too much surgery, but is it not better practice to effect a radical cure in a short time, when it can be done by so simple and safe a method as this, than to palliate and experiment, and rarely give complete or permanent relief by temporizing methods—just as it is better to extract a foreign body by surgical methods than to leave it to become encysted or be expelled by the process of suppuration?

I do not by any means advocate operative treatment in any case which offers a reasonable promise of cure otherwise, but I am convinced that in this direction we have not yet begun to do enough operative work instead of too much; and I believe it is our duty to the sufferers from chronic uterine displacements of the class I have described to give them the benefit of an operation which not only relieves but permanently cures them.

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## EPISIOTOMY.

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BY

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**T**HIS paper was prepared originally to be read at the last meeting of this society, in December, 1890, but not being able to be present then, it was not sent in. I now respectfully submit it.

Since the last meeting of this society a brief article has been written on this subject by Dr. T. Griswold Comstock,

and it will be found in the March (1891) number of THE HOMEOPATHIC JOURNAL OF OBSTETRICS. There he says: "With most American and English authors upon obstetrics, I find little said about it—by some not mentioned—but Professor Lusk, in his excellent work, is an exception. He describes the operation and recommends it."

Since about thirty per cent. of childbearing women have a lacerated perineum at some period in their lives, there is little wonder that this particular portion of the anatomy should receive a vast deal of attention. We regret to observe, however, that in these last years gynecological art has been much more devoted to the study of how to sew up a perineum than of how to prevent its laceration. It is not creditable to modern obstetrical art that so large a percentage of injuries occurs during parturition, that fifteen per cent. must be, and thirty per cent. are torn. One might almost be tempted to think that if the perineum were not so much of a support to the obstetrician, he would support it in more effective style. This is, perhaps, an ungracious support, and it may be that, in fact, the modern perineum, like some modern nerves and stomachs, is wearing out, and that perine-asthenia is another mark of our pampered and overwrought civilization.\*

The directions given by obstetricians for preserving the perineum are sufficiently numerous, elaborate, and positive, and we do not need to consider them here aside from our immediate subject. But each one has his pet procedure, and the general practitioner is liable, after trying one or two, to drop into prophylactic Nihilism, and allow them all to sink into innocuous disuetude.

We have been working backward in the department of obstetrics in that we have made so much of the matter of repairing the perineum, and so little of the prevention of damage thereto. Says Thomas Carlyle, "No ostrich, intent on gross terrene provender, and sticking its head into

\* *Med. Rec.*



fallacies, but will be awakened one day in a terrible *a posteriori* manner."

I, however, do not believe that the modern perineum differs materially, or at all, from that of our progenitors. While we know in the present day the condition of the perineum *post-partum* in every case of labor, it is because the modern obstetrician, and general practitioner, too, is more observant of *every* case and gives his personal and ocular (if need be) inspection to each. If there is anyone who does not, he should. I do not know how it is with city practitioners, but during a general country practice of over seven years I have found several among gynecological, as well as obstetrical, cases where there was an old and deep laceration of the perineum of which the patient was in some cases unaware. I have met several who have been in the care of an old practitioner, now retired, with lacerations complete, or nearly so, to the sphincter ani. When they occurred he had left them alone, either because he did not know of them or because he did not care to repair them. And if the patients knew of them he would pass them off with the remark that it would do no good to sew them up till after the period of child-bearing. Some have been great sufferers thereby, but so thoroughly had they become impressed with their former attendant's advice that they would not consent to operation. In the light of our present knowledge of orificial irritation what pernicious advice was his.

Formerly we used to hear general practitioners say that they did not meet with cases of laceration of the perineum among their obstetrical cases. And on inquiry we would find that they seldom or never gave their patients a thorough examination after labor. Had they been thorough and systematic in all their work I doubt not every one of them would have met with many surprises. However, this subject is not considered for their benefit, for such can seldom learn.

But for those who are faithful in all their work, who try to be armed for all emergencies, who are honest to acknowledge defeat when they meet it, and who are sometimes disappointed where they least expect it—for such the earnest consideration of this subject may be of lasting value.

It is surprising that so little has been written on the subject in comparison with the volumes that have been written and spoken on the subject of repair of lacerated perinei.

We are not studying in this paper the repair of a torn perineum, but that which I consider of vaster importance, viz., the prevention of the rupture of the perineum. The old adage that an ounce of prevention is worth a pound of cure is eminently true here, not only to the suffering patient, but also to the accoucheur. It is to fasten our attention in this direction permanently, I hope, that we will consider this subject to-day.

Episiotomy is the operation of incision of the labium (or labia) pudendi during the second stage of labor, for the assistance of the birth of the child or for the prevention of rupture of the perineum, and the immediate repair of the same after the birth of the child.

What are the indications for the operation? When the head during the second stage of labor presents at the perineum and threatens to rupture it deeply; or when the perineum is of sufficient strength to hold back the head.

I have somewhere seen it stated that there are three methods of making the incision:

First. In the raphe of the perineum.

Second. At or near a right angle to the raphe of the perineum on either or both sides.

Third. At an angle of forty-five degrees from the raphe of the perineum on either or both sides.

What advantage is to be gained by the first over and above the preference of an incised wound from a lacerated one is more than I can tell.

The last method is little better than the first.

The second is the preferable one, because (*a*) there is less muscular and fascial tissue to be incised, at the same time giving a vast amount of room for the perineum to be pressed downward and backward, and (*b*) because on repair healing is much better and surer.

One great and lasting objection to the operation in its first and third methods is that the lochial discharges may prevent healing after sewing up.

I understand that episiotomy is practiced in the Vienna Hospital.

I fancy that some overcautious persons will object to the operation because of the possibility of performing it at some time when it was not necessary. To which I reply: that while that may be possible, the simplicity of the operation is not to be compared with the enormities of a ruptured perineum, especially if it is completely through the sphincter ani. And when a rupture of the perineum begins you cannot tell where it will end.

When a rupture does occur in the perineum and it is complete to the sphincter ani, or through it into the gut, who can tell the mischief that will result therefrom?

We will aid ourselves to a proper realization of the importance of an intact perineum when we remember that many of the muscles which make up the perineal body blend with each other, and that portions of their attachments are either into each other or into the different fascia of the parts; and that in repairing the same it is impossible to restore the parts perfectly either anatomically or physiologically, and have them in the exact condition in which nature originally constructed them.

This whole subject was brought forcibly to my mind by a severe experience. The case was that of a primipara with instrumental delivery. Labor was severe and exhausting, and when I applied the forceps the mother was rapidly losing strength. The head was engaged in the superior

strait. Position, occiput right anterior. The child weighed  $11\frac{1}{2}$  lbs. and the rupture was through the perineum two inches into the gut. I did not deliver rapidly, and did not believe that an extensive rupture would occur; but when it did there was a report loud enough to be heard distinctly by all in attendance. The perineum was fibrous and inelastic. I repaired the rupture immediately, but, while the patient recovered, she was a long time convalescing. Mother and child are alive to-day. I then determined that, should I meet another such case, I would not allow rupture to occur if I could do anything to prevent it.

. There are times when realizations come over us sharp and painful—most painful because they pertain to ourselves. That we are growing old, for instance; that we are not perfect masters of our profession; that in the art of it we sometimes fail. For we cannot always cure disease or prevent accidents in times of emergency. Let such realizations, however often they may come, be our faithful teachers.

In severe labors, where the head has been detained at the ostium vaginæ, I have often in my early practice wished to incise the labia; but not having been acquainted with the merits of the operation, or with the authorities in support of it, and, I may confess, not even having seen any mention of the subject till a few months ago, and then not until I had once performed episiotomy, I was reluctant to venture. However, I did venture, and the first time of performing it may be worth describing.

On the evening of August 3, 1888, I was called to a primipara, aged thirty-seven years. Labor progressed normally till the head presented at the ostium vaginæ, where it could not pass. All the usual means for the softening of the labia and perineum had been used, but to no avail. They were of cartilaginous firmness and strength. Pains were very severe. After six hard pains and no progress I incised the

labia on one side only by the second method, and the next pain brought the head through, and the second one delivered the child, which weighed about nine pounds. Repaired immediately and healing was by first intention. When I made the incision the labia cut with the feel of cartilage.

During my practice here I have had 149 cases of confinement. Out of these I have performed the operation of episiotomy thrice and all the cases have healed kindly by first intention and the mothers have done well. Out of the 149 cases I have had only one case of puerperal fever, and that one case was from auto-infection, the woman having had metritis for three years previous to her confinement, and infection began within two hours from the birth of her child. I had previously by four months informed her and her husband of the probable dangers of the case. She died in less than seventy-two hours from the birth of her child.

There are perinei and perineei. Some are soft, pliable, and elastic; some of these may be thin, others thick. Other perineei are hard, coarse, fibrous, inelastic; some of these may be thin, others thick. These latter will tear, and when they do tear the rupture is almost always very irregular; especially is this the case with the thick ones. If the rupture is in the raphe it is inclined to heal slowly or not at all, but seems always glad to catch up any particles of infection that may come along. The inelastic perineei are the ones which cause so much trouble to the accoucheur. And they are the ones which demand episiotomy.

Those hard, coarse, fibrous, inelastic perineei, which are thick, are the most liable to rupture. I have found one or two cases where examination after birth has revealed a furrow through the fleshy or fibrous material of the perineum to the skin, but no rupture of the epidermis. These generally heal all right, but may need close attention for a few days; if, however, episiotomy is performed in time even this internal rupture is prevented. If obstetricians will

examine carefully *post-partum* every case of labor, they will find the above statements true.

The duties of physician to patient at all times are two-fold: to relieve present suffering, and to guard, as far as possible, against future ailments. But in no department of the practice of medicine are the duties of the physician of more importance, or of greater moment, than in the lying-in chamber. We must search the records of our obstetrical cases and see if we cannot become more efficient. Investigate the merits of this simple operation and secure all its advantages to those who are intrusted to our confidence and skill. There is no doubt but that the proper, judicious, and wise use of episiotomy would lessen materially the large per cent. of lacerations of the perineum.

It is well to hear so good an authority as Dr. T. G. Comstock speak on the subject. In his address before the American Institute of Homeopathy, held at Waukesha, 1890, he says: "It has satirically been styled 'the young practitioner's operation'; but it might be more properly termed the accomplished practitioner's operation."

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## MATERNAL IMPRESSION UPON THE FETUS.

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BY

M. A. BACON, M. D.,  
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THAT the maternal impression affects the fetus more or less must be admitted by all. Cases are on record where one or both of the parents were in a state of intoxication during coitus and the offspring coming into the world and maturing to manhood (if I may use that expression) with all the appearance of a state of continual intoxication.

If alcoholism will affect the offspring to such an extent,

what must be the effect of a powerful mental shock to the mother during the early stage of gestation !

In Carpenter's "Physiology," first American edition, page 596, he says: If a sudden and powerful emotion of her own mind exerts such an influence upon her stomach as to excite immediate vomiting, and upon her heart as almost to arrest its motion and induce fainting, can we believe that it will have no effect upon her womb and the fragile being contained within it? Facts and reason, then, alike demonstrate the reality of the influence.

Among the facts of this class there is, perhaps, none more striking than that quoted by the same author from Baron Percy as having occurred after the siege of Landau in 1793. In addition to the violent cannonading, which kept the women for some time in a constant state of alarm, the arsenal blew up with a terrific explosion, which few could hear with unshaken nerves.

Out of 92 children born in that district within a few months afterward, Baron Percy states that 16 died at the instant of birth, 33 languished for from eight to ten months, and then died, 8 became idiotic and died before the age of five years, and 2 came into the world with numerous fractures of the bones of the limbs caused by the cannonading and explosion.

Here there is a total of 59 children out of 92, or within a trifle of 2 out of every 3, actually killed through the medium of the mother's alarm, an experiment upon too large a scale for its results to be set down as mere coincidences.

There appear to be a sufficient number of facts on record to prove that habitual mental conditions on the part of the mother may have influence enough at an early period of gestation to produce evident bodily deformity ; might not, then, a severe mental shock at an early period of gestation produce the same results?

I will report one case from my practice where a severe men-

tal shock produced a serious deformity of the fetus resulting in premature labor at the seventh month and death of the fetus. I was called May 28, 1890, to attend Mrs. S., aged about thirty, mother of five children, all of whom were healthy and well formed; she was having hard and rapid pains, but said she was only seven months advanced. Upon examination, found the os fully dilated, a large sac of water protruding, the membrane very firm and tense. I ruptured the membrane, when quite a large quantity of water escaped. The pains then became more rapid. I then examined to determine the presentation; could find no fetus, but met another tense sac, which advanced rapidly with each pain. I ruptured it, when there came a perfect flood of water, wetting through two folded quilts and a straw mattress, and running in a stream upon the floor, filling an ordinary vessel that I placed to receive it nearly half full—the lady remarking that she guessed she had all gone to water. The fetus soon followed the rupture of the last membrane, but I was puzzled to know which part was presenting. However, I was not long left in doubt, for I soon delivered the most repulsive looking monstrosity I ever beheld. The body was well developed; the arms were flexed in a fixed position, the hands firmly closed as if grasping something, the face well formed to the eyebrows; from the supraorbital ridge to the inferior curved line of the occipital bone, including the parietal and temporal bones, all development had ceased. It had the appearance of having been dissected away. There was no brain development, except a small portion of the frontal lobes that was only covered by a thin, transparent membrane.

Upon inquiry as to whether she had received any shock during the early months of gestation, she had. When about the second month she was sitting near a window facing the barn doing some sewing, when she happened to look toward the barn just as a butcher was in the act of knocking down a beef to butcher it; she looked up just as the



blow descended, causing a terrible sensation in her head, as though the blow had hit her. She grasped her sewing with both hands, and it was several moments before she realized what she was doing, and several days before she could get the impression from her mind of the crushing of that animal's head. Without a doubt the destruction of the child was due to the impression upon her mind caused by the shock. She made a good and rapid recovery from her confinement.

I would ask if it is not invariably the case that where there is an arrest of development of the fetus there is an unusually large amount of amniotic fluid.

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## GLYCOSURIA DURING PREGNANCY.

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BY

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**I**N presenting a short paper upon the subject of glycosuria during pregnancy, I shall first report a case which occurred in my own practice several years ago.

The patient, Mrs. B., was twenty-six years of age, of medium height and weight. She had one abortion at the third or fourth month some years before, and had also had an attack of inflammatory rheumatism, with a resulting lesion of the mitral valve.

On July 29, 1889, being five months advanced in gestation, she complained that her discharges of urine were frequent and excessive in quantity; that the urine had irritated the parts so that there was more or less smarting and burning at the time of its passage.

I examined the urine and found it acid in reaction, with

a specific gravity of 1029. No albumen was present, but sugar was found in abundance ; as no quantitative analysis was made I cannot report the exact amount excreted in twenty-four hours.

Here was a case of glycosuria, and in searching for the cause I was forced to the conclusion that it was due in some mysterious manner to the fact of pregnancy, for the reason that there was no history nor evidence of trauma or exposure, no disturbing psychical influence, no indication of any central disease, nor other peripheral irritation to the nerves, and no discoverable disease of the liver.

In the treatment of this case uranium nitrate was the one and only remedy given until the sugar had almost entirely disappeared from the urine, which was in the early part of the following November. At this time the urine had returned to nearly normal in quantity, but albumen made its appearance, in small quantity at first, mixed with a little sugar ; it, however, increased rapidly in quantity, the urine at the same time diminishing, till the 20th of November, when it was found to be nearly suppressed and so albuminous that when boiled and the tube inverted not a drop was spilled.

Œdema of the lower extremities, abdomen, and vulva developed with astonishing rapidity. The vulva was so much swollen and so painful that my patient was obliged to remain in bed.

Various remedies were given for the purpose of relieving the kidneys and increasing the flow of urine, but without avail. Symptoms of uræmic intoxication developed, and convulsions seemed imminent. Frequent inhalations of the mixed gases—oxygen and nitrous oxide—were given, with the effect of relieving the severe pains in the head, the muscular jactations, and brightening up the patient generally.

On the seventh day, after being confined to bed, labor began. It was rapidly and easily accomplished, but the child was dead.

For several days the dropsy increased, and it was not until helonias was given that it began to diminish, which it continued to do until it was entirely gone.

The urine remained albuminous for four or five months after the dropsy had disappeared, but gradually returned to the normal.

Several complications occurred during the convalescence of this patient, such as urinary strangury, muscular rheumatism, and cardiac pains of a rheumatic character, but these were relieved by the usual remedies.

I have searched diligently for literature bearing upon this case and the following is the result :

In Dr. Mitchell's work there is a case reported by Dr. Brooks in which melituria developed during pregnancy ; labor was induced, and the sugar quickly disappeared. The child survived.

Dr. Mitchell has several times seen as high as 150 grains of sugar a day excreted during pregnancy. In one case the woman went to full term and was safely delivered, but the child was stillborn.

In the New York *Medical Journal*, 1871, Dr. G. M. Smith cites an instance wherein the wife of a physician died of diabetes a few months after marriage. The disease seemed to date from the time of conception. In the same article Dr. Smith mentions another case. In this instance the woman was suffering from diabetes at the time of conception, which greatly augmented the glycogenic process and in a short time produced a fatal termination.

According to Dr. Mathews Duncan, out of twenty-two diabetic pregnancies occurring in fifteen women four resulted fatally to the mother. Seven of the children died during gestation and two died a few hours after birth. One other was diabetic at birth.

Dr. Duncan found that diabetes developed during pregnancy may cease at the close of that period, or at the time when lactation ceases ; again, it may continue indefinitely.

He also discovered that occasionally a diabetic may conceive and pass safely to term, being apparently unaffected by the disease, while in others gestation may be terminated by the death of the fetus, or of both mother and fetus. Further, he observed that melituria may develop during lactation and disappear spontaneously at or near its close.

In *Annals of Gynecology and Padiatry* Dr. Fry says that over half the pregnancies in diabetic women end in death of the fetus and miscarriage. In case a healthy child is given birth by such a patient it is an indication that the disease has not reached a critical stage. To the woman the unfavorable prognosis of diabetes is accentuated by the coexistence of pregnancy. Mild cases assume acute forms and acute cases progress rapidly to a fatal termination.

From the foregoing it is evident that sugar may be found in the urine of a pregnant woman under one of two conditions: first, as the result of pre-existing disease, and second, as a complication which has developed during and in consequence of pregnancy.

We learn from the experience of Dr. Duncan and others that the glycogenic process is usually exaggerated in a diabetic woman by the coexistence of pregnancy. The manner in which this result is accomplished would be difficult to demonstrate. It has been ascertained, however, that during normal lactation the amount of glycogen in the blood is increased. This supplies the mammary glands with the necessary sugar to properly elaborate the mother's milk. This increased production of sugar is no doubt controlled in a reflex manner by the activity of the mammary glands, increasing or diminishing according to their needs. If for any reason the stimulation of the glycogenic centers be exaggerated, the amount of sugar produced will be in excess of the need of the mammary glands and will be excreted by the kidneys, producing a temporary glycosuria or aggravating an already existing diabetes.

PUERPERAL FEVER WITH MALARIAL COMPLICATION.

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BY

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AT 3 A. M., May 25, 1890, I was called to Mrs. P., whom I found had been in labor for several hours previous to our arrival. Examination revealed a vertex presentation with the head just engaging in superior strait and labor in every way normal, except a little slow. In due course of time a boy was born, the cord severed and tied, and the child given to an attendant. On making an examination to ascertain, as we supposed, how the third stage of labor was progressing, we discovered the breech of another child presenting, this time a girl. A few minutes after this second child was given to the attendant we delivered the woman of two afterbirths, due care being exercised to make sure that no shreds of membrane remained to cause disturbance. The uterus contracted normally and there was very little hemorrhage. The patient seemed to be in as good a condition as one could expect under the circumstances, and I left the house at about 6 A. M. The day was quite warm, also the first part of the night, but the latter part of the night was quite cold, hence the covering during the day and early part of the night was quite insufficient for the latter part, when the patient found herself quite chilly about three or four o'clock in the morning, and thought she could stand it till her husband arose about six. This, however, she was unable to do, as quite a severe chill came on about five o'clock, and she was obliged to call for additional covering, which she should have had two or three hours before. Unfortunately for our patient, we did not reach the house on this morning till ten o'clock, when we found her in a high

fever, with a marked tenderness over the region of the womb, with sharp, cutting pains, quite frequent and very distressing. There was some headache, aggravated by noise and light jar of the bed, etc. We gave her bell. every half hour, with only slight relief of the pains and none at all of the fever. Several other remedies were tried, with no better result. On the morning of the third day the pulse was 138, temperature  $104^{\circ}$ ; in the evening the pulse the same, temperature  $104.8^{\circ}$ , with delirium. The tenderness extended considerably, with meteoric distention of the abdomen, lochia becoming fetid. Hot compresses of dilute tincture of hamamelis was applied to the abdominal parieties, which had the effect to considerably lessen the pain.

The morning temperature on the fourth day was  $103.5^{\circ}$ , evening temperature  $104.8^{\circ}$ ; pulse 140 during the day. Considerable tympanitis was noted this morning, which increased toward evening. Lochia decreased in quantity and became more fetid. On the morning of the fifth day there was a little more remission of the fever than on the morning of the day before, and we were much elated with the thought that we could see our way through to the recovery of the case. But in the afternoon we were hastily summoned to her bedside and found her in quite a severe chill, with a temperature of  $105^{\circ}$ . The lochia had ceased to have any color or consistency other than a whitish gray pus of a very fetid odor. The abdomen was distended to its fullest extent and as tight as a drum, with labia and pudendi swollen. She was larger than before confinement, with increased delirium and nausea, with efforts to vomit. What was I to do? Bell., sepia, secale, rhus, and sulphur, each in its turn, selected after careful consideration, had failed to give us the desired result. Was this woman, who is now the mother of four children, all under three years of age, to die and leave the care of them to one of the most stupid of husbands? It certainly looked that way.

We carefully reviewed the symptoms from the first, and

summarized as follows: Fever sores on lips; remission of fever on two successive mornings; perspiration at night, with strong, feverish smell.

Chill, at an unusual time in puerperal fever, with warm perspiration, directed our attention to the possible malarial complication. The above symptoms, taken alone, are scarcely sufficient on which to prescribe but for the fact that *natrum muriaticum* at this time, and for some time past, has been my epidemic remedy for malarial fever. She received a dose of the 200th every hour during the remainder of the day and night.

Next morning, the sixth day, temperature 102°, pulse 120, with all symptoms greatly improved. In the evening the fever was less than in the morning. This, of course, was contrary to the usual course of fevers. The seventh day showed no fever in the morning, and only very little in the evening. The eighth and ninth days showed no fever whatever, with a very rapid improvement in all the symptoms, so that the patient made a rapid and complete recovery. The hot applications and dilute *hamamelis* tincture seemed to be of service only in lessening the pain, but nothing brought any marked improvement until the patient received *natrum muriaticum*.

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### A FEW RARE CASES IN GYNECOLOGICAL SURGERY.

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BY

CORNELIA S. STETTLER, M. D.,

CHICAGO.

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**I**N lieu of an original paper upon some gynecological subject, of which, doubtless, there will be no lack, I beg leave to report a few unusual cases that have recently fallen under my observation. In the capacity of assistant to Pro-

fessor Ludlam I have been privileged to study a number of these cases, and to take part in the operations that have been made for their relief and cure. Two of them occurred in his private practice, and the other is taken from the records of the Hahnemann Hospital of Chicago, neither of them having been heretofore published.

*A renal cyst.*—CASE I was that of a married woman, æt. thirty-eight. When about twelve years old she was thrown from a horse in such a way as to strike her shoulder and back. She was unconscious for some time, and afterward quite lame in the region of the kidneys. She was at other times thrown from her horse, but was not seriously injured thereby. About two years ago she met with another and similar accident while crossing the railroad track, when she fell and struck her back against the rail, from which she suffered severely, and for a while was obliged to keep very quiet.

She first observed a growth in her left abdomen about twenty months ago, and while she was pregnant; but there was not as much pain through the back and loins as before. Her child was born at term, sixteen months ago. A month later she experienced a dull, heavy pain, as if a weight were being moved, in the left and posterior side of the abdomen. Whenever she turned to the opposite side there was a sharp, cutting pain in the tumor.

For the last three or four years her urine has often been quite offensive, sometimes dark, with an oily scum on its surface, at other times precipitating a pink and grayish cloud near the bottom of the vessel. Her father, grandmother, and aunt died of diabetes.

Several physicians had diagnosticated the tumor as an ovarian cyst, and one specialist had been anxious to operate upon it for a fibroid of the ovary. Although Dr. L. had given his opinion that the case was almost certainly one of hydronephrosis, it was left to the abdominal incision to decide the question and to determine the expediency of



its removal. An exploratory laparotomy was therefore made at the patient's home in Minnesota, February 11, 1892.

The tumor was found to be a monocyst, and attached to the left kidney, which had been drawn forward toward the median line. It was a tense cyst, as large as a cocoanut, and had every appearance of a true hydronephrosis. It was tapped, and the contents withdrawn to lessen its size and to determine by the presence or absence of the urinary odor whether it was really that or something else. The fluid was sero-purulent, with a slight admixture of grumous blood from the bottom of the sac. When it had collapsed the cyst wall was found to be so firm, so intimately attached to the capsule of the kidney, and so grown into it by a broad base, that it became a serious question whether to dispose of it by separation, and thus incur the risk of a consequent hemorrhage if the kidney should be taken away with it (nephrectomy), or if the sac should be drained and its cavity closed by adhesive inflammation. The latter course was adopted as the safest and the best, and the patient's recovery has justified the wisdom of the course.

The points of especial clinical interest in this case are: (1) The diagnosis was very difficult because the usual relation of the colon to a renal tumor could not be made out; (2) the moral certainty that the cyst was of traumatic origin; (3) the thickness of the cyst wall and its thorough implantation in the capsule of the kidney; and (4) the serious surgical question of the propriety of trusting to drainage instead of nephrectomy in order to dispose of it.

*A suppurating cyst of the ovary included within the broad ligament.*—CASE II. Mrs. —, æt. twenty-four. She has been married two years, but has had no conceptions. Although she had complained of severe pain and distress in the left inguinal region of a dull, dragging character since 1889, her health was moderately good until the spring

of 1891, at which time she had an attack of the influenza. A few months prior to her marriage a slight enlargement was detected in the left abdomen ; but no especial heed was given to it. She never fully recovered from the effects of the grippe, and in the autumn she was confined to her bed with an attack of typho-malarial fever. She was also thought to be three months pregnant. Three months later she had a severe attack of malarial fever with its attendant symptoms of chill, fever, sweat, aching all over, severe headache etc., accompanied by pain of an aching character, which was sometimes acute, in the left side and corresponding ovary. An examination of the abdomen at this time revealed a smooth growth about the size of a four months' pregnant uterus, and as she was suffering with many of the symptoms common to gestation, as morning sickness, supposed quickening, almost complete suppression of the menses, etc., she was pronounced to be pregnant. As there had never been any irregularity in the menstrual function previous to this time, this supposed pregnancy was unquestioned by the patient.

The diagnosis was not clear, however, and an examination was again made by the attending physician, and the first impression that there was an abdominal tumor was confirmed. Hectic symptoms were developed and continued without improvement under medical treatment, and in February last a muco-purulent diarrhea set in. With the advent of the diarrhea the tumor almost entirely disappeared and it was with difficulty that it could be made out, whereas previously it could be plainly felt by laying the hands upon the abdomen. A week or two afterward the tumor could be as easily outlined as before, although it was not quite as large. Her general health improved somewhat, but up to the time of the operation she had not been free from the sweats, diarrhea, slight fever, and pain in the side.

Her mother died at the age of thirty-nine with ascites and an abdominal tumor.

April 3, 1892, a laparotomy was made in this case at Champaign, Ill. The incision disclosed a tumor as large as the adult head. The signs of fluctuation were masked and unsatisfactory, but a small, old-fashioned trocar and canula was plunged into it, and, passing its whole length, gave vent to about two ounces of stinking pus, when the flow suddenly stopped. The proper precautions having been taken to guard against overflow of this vile fluid, and being unable to find a pedicle for the tumor, the sac was incised and an included cyst was exposed to view. This inclosed sac proved to be a suppurating ovary with a firm capsule, and lying within the broad ligament, which had formed its outer wall. The interior cyst was then tapped and carefully drained of two pints of the same stinking stuff, after which it was shelled out and its attachments and adhesions carefully ligated. Sponge pressure, flushing, and drainage were depended upon to arrest the hemorrhage and to protect the patient from septic mischief. Under the faithful care of her physician, Dr. G. W. Redmond of Champaign, she has now made an excellent recovery.

The special points of interest are: (1) The obscurity of the diagnosis; (2) the development of this included cyst and its peculiar relation to the broad ligament; (3) the offensive character of the contained pus, which evidently had a causal relation with the first subsidence of the tumor; (4) the infectious nature of this pus as compared with the non-infectious pus when it has not in any way been exposed to the air; (5) the possibility of enucleating the sac in the same way as for other intra-ligamentous growths.

*Cyst of the uterus.*—CASE III. Miss —, æt. twenty-five, has been ill more or less since childhood. When fourteen began menstruating; the periods have been painful, irregular in recurrence, but normal as to quantity. This pain and distress she locates in the region of the ovaries, occurring usually one day previous to the starting of the flow and continuing during the same. Occasionally during a men-

strual period she escapes all symptoms; and if so gains in strength and seems quite well; but as a general thing she barely recovers from the effects of one period before it is time for another. Nausea and vomiting also accompany the menses and are controlled with difficulty. She suffers with bearing down in vagina, and rectum as well, which occurs independently, as well as in connection with the flow.

Upon local examination the vagina was found to contain a cyst which filled its upper portion and pushed the cervix so far forward and upward that the os uteri could not at first be recognized. This was finally found, but was so small as only to admit the passage of a small probe. The cervix proper could not be made out; for its tissues constituted the base of the cyst, which was found to extend along the posterior and lateral surfaces of the uterus as high up as the vault of the vagina, even to the inversion of the posterior *cul-de-sac*.

An operation was made in the clinic, April 20. The sac was first tapped by the aspirator trocar, but the contained fluid was too thick to flow through it. An incision was then made along its whole length and about four ounces of a honey-like fluid was evacuated. As it was impossible to enucleate this sac, its cavity was flushed and then packed with a strip of iodoform gauze, after which a tampon of the same material was passed to keep it in position. In a few days the wound was healed and the sac was obliterated.

The peculiar points in this case were: (1) the attachment of the cyst to the utero-cervical tissues, such cases being extremely rare; (2) the dysmenorrheal suffering, which was referred to the ovaries, the removal of which it was thought would be necessary for her relief; (3) the manner of disposing of the sac by drainage, and the aseptic packing.

## CONGENITAL PTOSIS.

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BY

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**W**HEN ptosis, or drooping of the upper eyelid, presents in children, it is almost always congenital.

It may affect one or both eyes and may be uncomplicated, or may be accompanied by other congenital malformations of the eye.

When ptosis is uncomplicated its symptoms are few. The lower eyelid preserves its motility and all its functions, but the upper eyelid falls in front of the eyeball, concealing more or less of the cornea in proportion to the degree of the affection. This descent of the upper eyelid narrows the palpebral fissure, and, in the language of the laity, the eye appears smaller than natural. In looking downward this falling of the eyelid will be but little apparent, but in horizontal vision, and in looking upward, the deformity becomes very perceptible. The effort to bring into action the elevator of the upper eyelid incites the action of the frontal muscle, drawing the eyebrows upward. When ptosis is bilateral and when it is of considerable degree, the patient inclines the head backward to bring the pupillary center opposite the narrowed palpebral fissure, thus producing the appearance of one peering from beneath the half-closed lids.

There is scarcely any other affection with which we might confuse this, exception being made in the case of sympathetic paresis of the eyelids, an affection in which ptosis is only one of a syndrome of symptoms. In sympathetic paresis of the eyelids the ptosis results from the preponderance that the orbicular muscle assumes as an

antagonist to the fasciculi of non-striated muscular fibers. Thus there results a slight ptosis of the upper eyelid which, together with a slight uplifting of the lower eyelid, narrows the palpebral fissure ; yet the patient still retains the power of voluntary lifting of the upper eyelid, even though he is impelled to associate a movement of the frontalis and the corrugator supercilii muscles. Other symptoms, showing the involvement of the great sympathetic system, fortunately assist in the differential diagnosis. These accompanying symptoms of sympathetic paresis of the eyelids are : \*

1. With regard to the eye : a marked myosis ; slight reduction of intra-ocular tension ; enlargement of the veins of the papilla.

2. With regard to the face : turgescence and redness ; increase of redness of the whole countenance (especially the ear).

Finally, this disease has not yet been reported as occurring in children, and is only likely to be present in a case where there is direct pressure on the great sympathetic in the cervical region.

When ptosis occurs in young girls there may be a possible question between a reflex ptosis and a congenital ptosis ; this, however, could only be confusing when the history of the case has been neglected. It will be interesting to note that ptosis of an hysterical or of a reflex nature has been reported in cases cited by Canton, Cooke, and Mavel. Here the ptosis is of spasmodic character, and excited by amenorrhœa, hysteria, etc.

Ptosis of the congenital variety pure and simple is rare. Out of 13,661 diseases of the eye, examined in the ophthalmological department of the *Clinique des Quinze-vingts*, there were only five recorded as congenital ptosis. In relation to other forms the proportion taken from this clinic

\* De Wecker, "Manuel d'Ophthalmologie," 1889.

gives us five cases of congenital ptosis to eight of other varieties.

The proportion in which complications present with congenital ptosis is not known. Although I have never seen a case in which there were accompanying congenital lesions of the eye, Galezowski states that this deformity is rarely isolated. On the contrary, de Wecker believes that of all congenital anomalies of the eye, ptosis is most often observed without any other vice of conformation of the bulbus oculi and its annexes.

The usual deformities associated with congenital ptosis are epicanthis, coloboma of the eyelids and iris, and dermoids of the cornea, all indicating participation in the arrest of development that has resulted in absence of the *levator palpebræ superioris*.

As an acquired deformity and complication we sometimes see abnormal attitudes of the head. On account of the inability to raise the eyelids in bilateral congenital ptosis of marked degree, children may acquire the habit of carrying the head backward or inclined toward one shoulder.

As a rare and peculiar complication of congenital ptosis we have to cite those cases in which a mobility of the upper eyelid is associated with movements of the lower jaw.

The first of these cases was noted by Gunn before the Society of Ophthalmology of London in 1883. In this case, in which the ptosis was of slight degree, the upper eyelid was elevated during forced downward and lateral (to the opposite side) movements of the lower jaw. In a case reported by Reuss the victim of a congenital ptosis could raise the upper eyelid when he used the muscles innervated by the fifth nerve, especially when the mouth was opened. Analogous cases have also been reported by de Wecker, Proskauer, Helfreich, Uthoff, Foerster, Bernhart, Laqueur, and Just. In commenting on these cases Proskauer divides the twelve cases he was able to gather from the literature into two groups; one where congenital ptosis was present

(ten), and one where the ptosis was absent (Fuchs, Just). Opening the mouth produced widening of the palpebral fissure in all; but only in four cases, movements of projection and lateral motions had influence. These physiological curiosities are probably due to fibers from the motor nucleus of the fifth nerve forming a portion of the nerve supplied to the elevator of the upper eyelid.

Lastly, M. Armaignac \* reports a case of congenital ptosis accompanied by complete congenital paralysis of the superior rectus. This occurred in a child of two years. There are strong probabilities that the superior rectus was incompletely developed rather than that it was paralysis pure and simple. This for the reason that there was no history of convulsions or of serious disease, that the fontanelles were perfectly ossified and the cranial sutures normal, and that the orbital region of the affected eye was somewhat atrophied.

The pathology of congenital ptosis lies almost wholly in the domain of theory, so far as an opinion is concerned when one is confronted with an individual case.

In a general way we can distinguish three varieties: *hypertrophic*, *atrophic*, and *paralytic*. There is also a form which has been confused with the hypertrophic condition. This form is due to a congenital relaxation of the integument of the upper eyelid, and Galezowski has demonstrated that the condition is not an hypertrophy of the elements of the skin, but a simple looseness and drooping of the integument, from congenital absence of attachments to the subjacent muscular tissue.

The *hypertrophic form* relates to a congenital excess of development of the integument of the upper eyelid. This condition, then, is one of relative insufficiency of the *levator palpebræ*, the power of this muscle not being great enough to oppose the weight suspended from it. The other two varieties lie within the domain of absolute insufficiency.

\* "Mémoires et Observations d'Ophthalmologie Pratique."



The *atrophic form* is either a condition of congenital amyosthenia or one of complete absence of the elevator of the upper eyelid. It is the result of a default in the development of this muscle, and exists without elongation of the eyelid and without an excess of integument. In fact, the covering of the upper eyelid is often thinner than normal from an associated lack of development in the skin and muscular structures beneath it.

The remaining variety, *paralytic ptosis*, is truly an incomplete paralysis of the third pair of nerves, engendered by accidents affecting the encephalon during labor. It may be the possible result of compression of the head in the pelvic cavity or of a badly directed pressure from the obstetrical forceps. Galezowski also advances the idea that this form of ptosis may be due to a congenital alteration of the motor nerves of the eye, indicating a central change. In children affected by this form of congenital ptosis he has observed the occurrence of epileptiform and convulsive attacks during early childhood.

Much of what has been said on pathology covers the question of the pathogeny of this affection, but I wish to mention the hereditary factor in causation. The atrophic form, or congenital absence of the levator *palpebræ superioris*, is particularly an hereditary trouble. Alessi and Caffé have reported cases of this variety as being hereditary. De Wecker states that when hereditary ptosis occurs it always affects the same side in members of the same family. Dagnillon relates an interesting case in point: \* A young man of twenty-one years presented a partial congenital ptosis with a divergent strabismus. All the antecedents of this patient, that is, in the ascending male branch, except the father of the young man, suffered from the same affection in the same eye. There was no history of consanguinity.

The question of treatment for congenital ptosis largely

\* *Bulletin de la Clinique Nationale Ophthalmologique de l'Hospice des Quinze-vingts*, 1887, No. 2, p. 177.

relates to surgical measures. When the condition is due to congenital absence of the elevator of the upper eyelid; it is evident that its correction must be by mechanical measures; but when the hypertrophic or the paralytic form is present, a trial of homeopathic therapeutics may yield beneficial results.

With regard to remedies I have no one especial drug to recommend; remedies for ptosis in general will cover this particular variety, but I do wish to say that good results can be expected only when the anamnesis has been thoroughly canvassed, especially with regard to antecedent dyscrasias. When a history of hereditary ptosis exists let me put in a note asking attention to the medication during pregnancy, for which our friend, Dr. Geo. W. Winterburn, has entered so efficient a plea. At the same time I wish to bring in view the reverse side of this question, namely, that it will be well to include in the anamnesis of congenital anomalies all that can be ascertained of the mother's condition during gestation.

The early surgical measures for the correction of ptosis were not only severe but partially erroneous in principle. A section of the integument was removed from the upper eyelid, with simultaneous resection of a portion of the orbicularis and of a part of the tarsal cartilage and of its suspensor ligament. As a result, the operation was followed by a secondary lagophthalmus or by an ectropion. It was only in 1879 that Dransart inaugurated the correct principle by passing catgut threads under the skin of the eyelid, bringing them out at the eyebrow and thus establishing cicatricial bands which supplemented the effect of the *levator palpebræ*. Pagenstecher, de Wecker, Panas, Bowman, and others have followed, until we now can make a choice from quite a variety of operations.

In hypertrophic ptosis, where the excess of integument is the chief factor, the most simple operation consists in excision of a small, transverse, cutaneous fold; but this is

the only form in which such an operation has any chance of success. This is performed as follows: With a simple dissecting forceps a fold of the exuberant skin is seized at some distance from the edge of the lid, in a situation where the resulting scar will be hidden by the natural folds of the eyelid. When the fold of skin is well under control

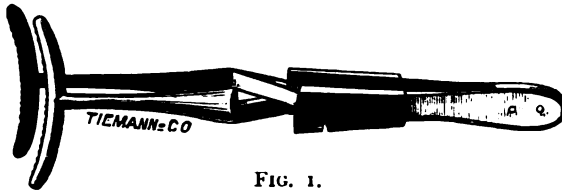


FIG. 1.

the eye should be opened and closed, to be certain that lagophthalmus will not result.

Three or four sutures are passed through the skin outside the edges of the intended incision. This done the cutaneous fold is excised and the wound closed by securing the sutures. If it is found necessary to excise a large portion of the integument a special pair of forceps (Fig. 1) will be found essential to quick work.

In the above and in the succeeding descriptions a por-

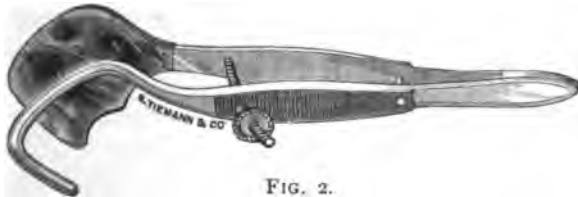


FIG. 2.

tion or all of the following instruments will be of use, according to the experience and methods of the operator: Snellen's forceps (Fig. 2); scalpel (Fig. 3); Jaeger's plate (Fig. 4); tarsorrhaphy knife (Fig. 5); Beer's knife (Fig. 6); dissecting forceps (Fig. 7); sharp-pointed curved scissors; needles and needle holder.

When the *levator palpebræ* is absent, partially or wholly, or when it is affected by a congenital paresis, it is necessary to resort to a method which establishes a functional equilibrium between this muscle and the orbicularis, either by giving the levator some aid to supplement its action or by weakening its antagonists. It may also be necessary to combine both these methods.

Von Graefe proceeds as follows: At five millimeters from



FIG. 3.

the free border the skin of the upper eyelid is incised to its whole extent. By exerting traction on the lips of the incision they can be widely separated, with a slight dissection of the subcutaneous tissue. The orbicular muscle being thus exposed, a portion of it is taken up with the dissecting forceps and eight to ten millimeters of its structure are excised with the scissors, leaving the orbital aponeurosis intact. Two to four sutures are sufficient to close the

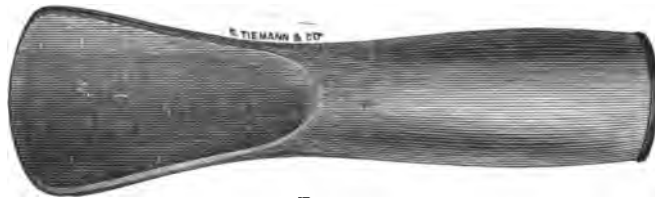


FIG. 4.

wound. These sutures should include the lips of the wound in the muscle as well as those of the incision in the skin. When the lid has undergone abnormal elongation it becomes necessary to excise a cutaneous flap also.

Galezowski removes from the upper half of the tarsal cartilage a section of 1 to 1½ and millimeter, including the skin and the muscular layer. The wound is closed

by four to six sutures passed through the whole thickness of the lid, including the tarsal cartilage.

Bowman reverses the upper eyelid and excises the upper border of the tarsal cartilage, with the contiguous tissues. The levator, inserted in the cartilage, is naturally included in this incision. The edges of the wound are united by very fine sutures. Bowman believes that the tendon of the levator muscle is thus shortened and its force increased.



FIG. 5.

Gillet de Grandmont\* proposes the following as a new operation for congenital ptosis:

1. After having included the eyelid in Snellen's forceps incise the integument parallel to the free edge of the lid, at a distance of three to four millimeters and to a length of  $2\frac{1}{2}$  centimeters.
2. Lift up the cutaneous flaps, detach and excise in a corresponding portion the orbicular muscle, in a way to lay bare the whole of the tarsal cartilage, almost to the ciliary

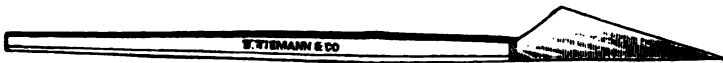


FIG. 6.

border, to and comprising Sappey's orbito-palpebral muscle, and the tendon of the levator.

3. Incise the whole thickness of the tarsal cartilage, to an extent of about two centimeters, parallel to the free edge of the lid at a distance of from two to four millimeters from this border.
4. Describe a curvilinear incision with an inferior concavity from one extremity of the first incision of the cartilage to the other. This incision should occupy the

\* "Nouvelle Opération du Ptosis Congenital," *Rec. d'Opht.*, 1891, p. 267.

whole thickness of the tissues, so that with the section removed the plate of Snellen's forceps is visible.

The tissues comprised in this excision are of no importance; they are for the one part composed of the tarsus, for the other, of the orbito-palpebral muscle. The important item is that the height of the section should be sufficient to correct the ptosis.

5. Suture, with three stitches of catgut OO, the upper, or orbito-palpebral lip to the lower, or the tarsal lip of the wound, without including the skin.

The skin flaps give no concern; their approach follows these sutures immediately, and all that can be perceived is a cutaneous fold corresponding to the natural fold.

Nicati\* has adopted a useful modification of Bowman's operation that will be found very successful in ptosis of



FIG. 7.

slight degree, but it is impossible that it should be of benefit where the upper eyelid hangs far down. He operates as follows :

1. Inversion of the upper eyelid.
2. Pass, one after the other, the two extremities of a suture into the fundus of the conjunctival *cul-de-sac* behind the tarsus. This suture is buried beneath the skin and the ends are brought out just behind the cilia.
3. The ends of the suture are tied very strongly.
4. The excess of the tarsus is excised, but the conjunctiva is preserved.
5. The sutures are removed after three days.

The operative methods which now follow are all modifications of the principle introduced by Dransart about 1879.

\* *Arch. d'Oph.*, t. x. p. 162.

The elevation of the upper eyelid depends in this upon the formation of cicatricial bands which assist the *levator palpebræ*.

Dransart describes his procedure as :

1. Incision of the upper eyelid the length of the upper border of the tarsal cartilage.

2. Dissection of the skin as far as the superciliary muscle in a way to lay bare the upper part of the orbicular muscle.

3. A needle, armed with a catgut suture, traverses the upper edge of the tarsus at its middle portion, from the superficial toward the deep surface. When the needle has penetrated almost the whole thickness of the cartilage it is directed toward the superciliary muscle, taking care to push it beneath some thickness of muscular fibers and cellular tissue. Arrived beneath the eyebrow the needle is drawn out, carrying the catgut suture into the track it has pursued. Two other sutures are passed in the same way to the right and left of the median thread at a distance of six to eight millimeters. These sutures are secured and the flap of skin dissected will fall naturally into its place.

Professor Gayet of Lyons proposes to modify this procedure by the use of the galvano-cautery.\* In the place of using silk or catgut Gayet employs metal sutures passed by means of hollow needles. When the wire is in place it is heated by the electric current and then withdrawn. In this way a subcutaneous burn is obtained.

The fact that ordinary catgut is sometimes absorbed too early has lead M. Dehenne to employ catgut prepared in a solution of naphthol. He found by experiment that this preparation considerably retarded the absorption of the catgut.

Pagenstecher, following immediately after Dransart had published his method, simplified the use of the suture by the following: A thread, armed with a needle at each extremity, is made to take up a small bridge of skin (one

\* *Arch. d'Oph.*, t. xi. p. 345.

to two millimeters) near and parallel to the center of the ciliary margin. This is accomplished by passing each needle vertically beneath the skin and bringing it out above the eyebrow. Here the ends of the suture are tied above



FIG. 8.—De Wecker's Method.

a bit of kid or of rubber drainage tube. When a more extensive effect is necessary these ends are drawn upon every day, and tied again, until the loop of the suture cuts a track for itself by following the whole length of thread.

In cases of a considerable degree of ptosis my judgment and experience is in favor of de Wecker's method,

a combination of Graefe's and of Dransart's operation. This author gives his procedure in a late work.\* We resect an oval flap comprising the skin and the orbicular muscle, or involving the muscle alone, by an incision at four to five millimeters from the free edge of the eyelid. Closing of the wound and elevation of the lid is obtained by two sutures placed as follows: With a needle threaded with silk we penetrate at a point situated above the eyebrow (*a*, Fig. 8); gliding beneath the skin and muscular tissue, the needle issues from the upper part of the wound under the excised orbicular muscle. Again the needle enters below the orbicular muscle near the lower part of the wound, and



FIG. 9.—De Wecker's Method.

\* "Manuel d'Ophthalmologie," 1889.



makes its exit in the center of the cutaneous strip. A bridge of five to six millimeters being preserved, an inverse course is followed to an exit above the eyebrow (*b*, Fig. 8). A second suture is placed in like manner about one centimeter from the first.

Gentle traction allows us to close the wound and it coapts marvelously well. Then the ends of the suture are tied in a bowknot above a bit of disinfected drainage tube (Fig. 9). If care has been taken to provide an aseptic silk the suture may be left for some weeks and tied again from time to time. The threads terminate by cutting through the small bridge of tissue left below the incision.

Among the remaining methods that are modifications of Dransart's procedure there is but one which deserves consideration from the surgeon. This is an artistic design presented to us by Professor Panas. Its author claims for it the advantage of giving the eyelid a natural form, while restoring the mobility. This method is, however, very laborious, and it is doubtful if better results can be secured than with de Wecker's operation. I give you the description in the words of his pupils.\*

The surgeon cuts a small flap of the form presented in Fig. 10. The base of this flap will correspond to the

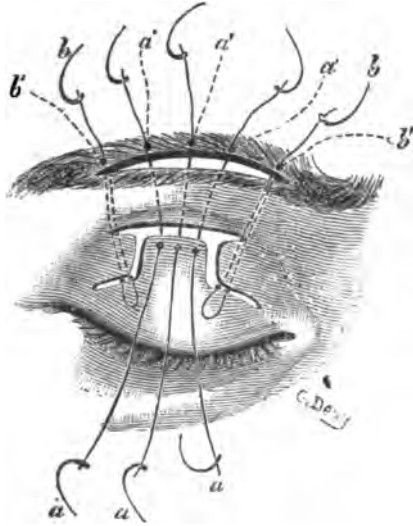


FIG. 10.—Design of the Flap.

\*"Traité Pratique des Maladies des Yeux Chez les Enfants," Saint Germain Valade, Paris, 1887.

adherent border of the tarsus, or, if desired, to the groove which separates the tarsal portion from the orbital portion of the eyelid; the apex will be determined by the groove marking the separation of the lid from the eyebrow. The tracing of the flap being completed, it is dissected from above downward, *including the muscle* in its thickness. The

dissection should pass between the muscle and the tarsal cartilage.

Finally, a curved incision is made immediately above the upper border of the eyebrow and parallel to this border. This incision should be deep enough to lay the periosteum bare (Fig. 10).

Then the musculo-cutaneous bridge comprised between the two superciliary incisions is

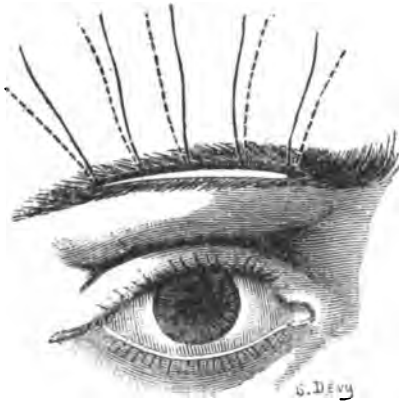


FIG. 11.—Palpebral Flap Drawn Upward.

carefully dissected, preserving the suspensory ligament and the frontal periosteum.

After detachment of the superciliary bridge it is drawn downward. The border of the palpebral flap is then brought in contact with the skin of the forehead and with the frontal muscle. Three stitches (*d d d*, Fig. 10) fix the eyelid in this situation. To avoid the dangers of ectropion it is well to place two lateral sutures (*b b'*), which reunite not only the integument in the flap but the suspensory ligament of the conjunctiva to the skin of the forehead (Fig. 11).

At the moment of operation it is necessary to graduate the effect of the sutures in such a way as to produce an hyper-correction. This will diminish later and the desired effect will be obtained. The stitches should be left in place until the fifth or sixth day.

## SIMILIA IN OBSTETRICS.

BY

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A CHILD to be born right must have parents who are in both physical and mental equilibrium—"like begets like!" and here begins similia in obstetrics.

There is much ignorance among married persons, even among those who have a desire to be right, as to the sexual relation. Most of them, especially the men, look upon it as a means of gratifying a physical craving. Sexual desire is mental or spiritual, and is strong or weak, according to the physical development and strength; an ill-favored child will be found to have been begotten while the parents were not in spiritual harmony. While the sexual passion, which is common to all animals, is looked upon as the lowest of all passions, it is so only because it is the foundation upon which is built the most elevated superstructure of love between man and woman. A given spiritual state between the parents begets similia in the child. One case in illustration: It struck me while talking with a man five years married, the father of two children, that he understood neither the physiology nor the psychology of marriage, although he and his wife were happy. I gave him a lecture, with the result that his wife, to whom he repeated it, became pregnant at the next intercourse, which, as he told me, was the most satisfactory since marriage. My prediction to her was that the child would be one of the happiest, prettiest, and best dispositioned child ever born, which was fully realized. The labor was easy. These parents are of a high type of manliness and of beauty, but all may accomplish the highest of which they are capable by observing similia.

The child begotten, it is unnecessary to argue before this society for the similar remedy to meet the ailments of pregnancy; but one point seems to me important, viz., the indications for the remedy will not be found in the diagnostic symptoms of the uterus or its appendages, or even in the peculiar diagnostic symptoms. Of what use is the symptom morning sickness? If the nausea of pregnancy comes at an unusual time, then it may be characteristic. When with the nausea after a 5 P. M. dinner there comes a very full feeling, urine dark but without sediment, weak feeling about 11 A. M., lycop. will straighten all that is crooked; if there should be nausea in the morning, better after eating, loose bowels, frequent profuse urination, worse at night, and a weak feeling about 11 A. M., sulph. will help the patient. In a case where with the nausea there was ptyalism which turned the teeth black arg. nit. helped, but did not cure; nothing ever helped before.

I am a believer in Dr. C. Hering's theory that there is but one normal position for the fetus; the abnormal positions I believe to be due as a rule to causes (not accidental) which may be removed to a greater or less degree by *similia*. My experience is confined to two cases, both under puls. The first was at about six months and was changed the second night during sleep from a cross position to vertex. The symptoms for which puls. was prescribed passed away with the change of position. The second case was in labor and was changed in two hours from a cross position to breech—second child and delivered without trouble. The accompanying conditions led me to believe that the version was not spontaneous.

As to puerperal eclampsia I cannot speak, never having had a case; but I remember reading a report made to a society in the early days of homeopathy in this country that *all* cases treated homeopathically *recovered*. In these days we ought to try before emptying the uterus; the cause precedes the pregnancy.

A pregnant woman should have no sense of the process

of dilation ; if she is suffering during an ebb tide shall we go about our business until the flood and let her suffer? Hardly, although children should be born in flood tide. I have not always found the remedy, but when I have the response has been prompt and satisfactory. Such a case was as follows: Mrs. B., a fat primipara, had such an irritable hymen that dilating had to be resorted to, after which she became pregnant. When I essayed to make an examination she made so much resistance that I desisted for thirteen hours, when, in spite of her kicking and screaming, I found the cervix like a virgin's, and hard. Then I sat down and watched her. She looked exhausted from suffering for so long a time, and was pale, but would flush with the pains, which came and went quickly, so that her commands to hold her back were quick, impulsive, and imperative. She would not lie down. The vagina was hot and dry, although no examination had been made ; her disposition is gentle and cheerful. Wondering that I had not seen the remedy before I gave bella. 200 with instructions to repeat in twenty minutes, which was done, after which she slept for half an hour and woke with expulsion pains and a changed expression. In one hour and a half from the first dose the child was born. So it may be under the similar remedy, other things being right.

That the placenta may be expelled under the stimulus of similia I have no doubt, but in a tired woman it works slowly and I *suggest* to the uterus, by pulling on the cord, the necessary pains and expulsive effort—a similar force, but not the same as the Cr  de, which I regard as too barbarous except for Frenchmen.

With antiseptics I have nothing to do except through similia ; nor in fact have I ever had that much, for I have never had but two cases that even threatened sepsis. The first yielded several times to the similar remedy and at last, when my positive orders were carried out by the shiftless mother, and the bowels emptied, all the symptoms disappeared, explaining what I could not account for—

stupor, dry, streaked tongue, fever, etc. The second patient had three chills, due to scientific douching by a scientific nurse, who did not see fit to consult me about her business; but all was controlled with arsen. 200. How any homeopathic physician can negative all his claims, all his experience, and all his deeds with the similimum by running after old school proceedings which are scientific only in name, and oppose and shock Nature instead of aiding her, is more than I can comprehend; how they can teach that you must give large doses of quinine because a puerpual patient has a chill is beyond comprehending. A puerperal patient does not differ from another except in that she is in better condition to help the physician than one who has accumulated disease through a long period of time. If there are putrefying membranes or clots set the woman on the comode, give her the remedy indicated, and they will come away. Don't substitute a mineral poisoning for an animal poisoning; the patient will take care of what comes from within. What she has most to fear is that which comes from without and which needs only good soap, water, and a nail brush to prevent. When your hands have been well cleaned rinse in alcohol if you are not satisfied, or salt water.

Finally, I declare my solemn belief in and adherence to the law of similia in obstetrics as well as in all abnormal conditions.

Allah is great and Hahnemann is his prophet!

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Dr. L. Ridgeway Barber, in the *Med. and Sur. Reporter*, discusses the question of administering chloroform in women who have organic heart disease. He concludes that chloroform by inhalation can, and will if properly administered, save the lives of parturient females, suffering from organic disease, when death seems imminent from over-stimulation of its ganglia through reflex nervous action. Organic heart disease does not preclude the use of chloroform in labor.

PECULIAR CASE OF CHILD BEARING.

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BY

WILLIAM C. DAKE, M. D.,  
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**M**RS. L., white, the mother of two children, menstruated May 17 to 21, 1891, and soon after became pregnant.

During pregnancy she had a severe cold, troublesome cough, oppressed breathing, and diarrhea, and, finally, an attack of la grippe, which precipitated labor early on the morning of December 17.

A vertex presentation was found; the labor was rapid and in a short time a child was born, small, but plump and living.

So far advanced was labor on my arrival that no examination of the abdomen was made and there had been no reason to suspect twins from anything previously observed; but on passing my hand into the vagina to remove the placenta none was found, but instead, the breech of a second child, which was in a few moments delivered, living, but smaller and thinner than the first.

In a short time the placenta was removed and was unusual in that there was but one for the two children.

On examination the placenta proved to be larger than an average single one, and the surface was marked into two parts by a membranous septum, about an inch from either side of which was attached an umbilical cord. One cord was round and full, yellow in color, having the appearance of being fatty. The other was small, bluish white, and had no appearance of fat. A comparison of the cords attached to the placenta with the stumps attached to the children indicated that the first child born, the plumpest, had been connected with the placenta by the yellow, fatty appearing cord; while the second child, having every appearance of

being poorly nourished, had been connected by the small, bluish white cord.

The children in appearance were like miniature Chinese, in sex female, both together weighing four pounds; were too small and weak to nurse the breast, and had to be fed on milk from a teaspoon.

From the first day of the last period to the day of delivery was seven months; and from the time of conception to end of term six months and two weeks.

The plumpest and apparently best nourished child died on the twelfth day, while the other, thin and poor, survived until the twenty-first day after birth.

I might have doubted as to the time of conception but for proofs which I cannot here detail, quite satisfactory to me.

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### A CASE OF PLACENTA PRÆVIA.

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BY

JULIA CHAPIN JUMP, M. D.,

OBERLIN, O.

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MRS. F., a multipara, engaged me to attend her at her approaching confinement, then very near, and gave me the following history: She was the mother of two children and had miscarried once at about four months. She had never nursed a child, as no milk was secreted. Although not strong, her general health was good. She had taken no medicine since childhood. During this pregnancy she had performed more severe manual labor than ever before and yet she was perfectly well. She assured me that she would need no care till labor set in, as she always had an easy time.

One Saturday night she had a peculiar sensation—not pain, but a strange nervousness; and as her husband was absent



and would not return till the following Monday eve, she called in a friend, who spent the night with her. Sabbath morning there was some show of blood, which gradually increased through the day and continued Sabbath night.

Monday morning, notwithstanding the flow, she dressed and walked through a long cold hall, and sat down to breakfast. Up to this time the motion of the child had been vigorous. As she took her seat there was a gush of blood, as she expressed it, from the uterus, and she felt no more motion. She returned unaided to her bed and again summoned her friend, but did not call me, as she had no pain. About 8 A. M. they decided to call me. In five minutes I was at her bedside. I found her blanched, pulse quick and feeble, but not alarmed.

On examination I found a pool of blood in the bed, and the vagina filled with clots. The os was widely dilated, and a placenta prævia centrally attached entirely covered the os. There was a rupture through the placenta prævia large enough to easily admit my hand. No part of the child presented.

I sent my carriage for a brother physician and also sent for my student. The doctor gave chloroform and I delivered the woman, making podalic version. When my hand entered the uterus I found an hourglass contraction above the placenta, the child being entirely in the upper portion.

There was still no pain, and no sign of expulsive contraction.

By steady, gentle pressure I so far overcame the hourglass contraction as to reach and bring down a foot, when the contraction shut down on the thigh; the other foot was then brought down and the body was grasped by the contraction. So step by step I finally succeeded in delivering the child. It was bloodless and resembled marble in color. As soon as the child was delivered the circular fibers relaxed.

The placenta was delivered immediately, but still there

was not the slightest contraction. I asked the doctor to compress the uterus through the abdominal walls, and gave her fluid extract of ergot, forty drops in divided doses. I then relieved the doctor. It was like trying to compress a large rubber ball. The uterus resembled an inverted stone jar, the circular fibers corresponding to the circular ridges of the jar.

In a few minutes the ergot took effect and the uterus shut down in firm, tonic contraction. My student kept her hand over the fundus over an hour.

Leaving the patient on china 3x I went out to make some calls, seeing her several times during the day.

When the husband returned I insisted on having a good nurse secured. He replied, "No one but myself can care for my loved ones." The wife also insisted that no one else could care for her. The friend before mentioned did what she could. All went well till the third day, when puerperal fever was ushered in by a severe chill, the temperature rising to 105° in a short time. The fever lasted two weeks. The remedies given were aconite, bell., china, puls., and hyoscyamus.

The patient made a good recovery. As the woman and her husband were Christian Scientists the case was a difficult one to manage, as it was almost impossible at times to induce her to take the medicine.

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## ON THE CAUSE OF DIPHTHERIA.

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BY

O. EDWARD JANNEY, M. D.,  
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MORE progress has been made during the past year in the ætiology of diphtheria than at any time since 1883, when Loeffler discovered and Klebs described the bacillus which has been named jointly for them.

The researches of bacteriologists have made clear the way to certain conclusions, with which nearly all are agreed.

In the first place there is general acquiescence in the belief that the immediate cause of diphtheria is some irritant, either chemical in nature or else belonging to the bacteria.

That the species of bacteria so acting is that known as the Klebs-Loeffler bacillus.

That this bacillus remains on the surface of the mucous membrane in diphtheria and does not enter the tissues or pass to other parts of the body, except in rare instances.

That a disease resembling diphtheria and accompanied by the characteristic diphtheritic pellicle has been produced in animals by inoculation with cultures of the Klebs-Loeffler bacillus. This much is generally admitted by all. We now, however, enter upon debatable ground.

It would appear from investigations made recently, some of them during the past year, that diphtheria must be regarded as occurring in two forms, *i. e.*, true diphtheria and pseudo-diphtheria. *Especially attention is called to this distinction.* In true diphtheria may always be found the Klebs-Loeffler bacillus; in pseudo-diphtheria it is never found. True diphtheria is attended by blood poisoning, nephritis, and paralysis; in pseudo-diphtheria there is neither nephritis or paralysis and seldom blood poisoning. When the latter is present it is not attended by the peculiar symptoms of diphtheritic poisoning.

Pseudo-diphtheria closely resembles membranous croup, if it be not identical with it, and we are now at last in a position to say definitely wherein croup differs from diphtheria. Further, it should be noted that while croup or pseudo-diphtheria may cause death, this result is produced in nearly every case by obstruction to respiration and exhaustion, and not by blood poisoning or paralysis, as in true diphtheria.

It has long been known that a false membrane may be produced by various agents, such as steam, carbolic acid,

chlorine, and ammonia. In such instances, however, the Klebs-Loeffler bacillus is never found, and these cases may be classed as pseudo-diphtheritic. So also may those twenty cases of membranous affection of the throat, examined by Prudden in 1890 and called by him diphtheritic, in which the bacillus of Loeffler was not found, and which, for a time, threw doubt upon the theory of the Klebs-Loeffler bacillus being the cause of true diphtheria.

The agencies which produce pseudo-diphtheria, therefore, are numerous, but their consideration, while interesting, must be set aside for the present to allow inquiry as to the cause of true diphtheria.

In the first place the query arises, Why should there be any formation of a false membrane? To this we can only answer that there is a tendency in certain individuals to the formation of such an exudation, under certain conditions. It is well known that the children of certain families are peculiarly liable to have croup and diphtheria. Whether these membranes are the result of the action of drugs, micro-organisms, or other immediate cause, there is, at the foundation, this predisposition in the individual.

But, given the predisposition, there must be an immediate cause, and that the immediate cause of true diphtheria is the bacillus of Loeffler and its resultant ptomaine is as clearly proven as are many points in ætiology and pathology which have passed beyond the period of question into that of acceptance.

Let us glance for a moment at the facts of the case. As has been mentioned, true diphtheria differs from other varieties in that it is accompanied by blood poisoning, nephritis, and paralysis. But, according to the observation of all, these symptoms do not occur in diphtheria unless the bacillus is present. These phenomena are not those of ordinary septic infection, but form a triad peculiar to diphtheria; and, as they are the same in kind in all cases of true diphtheria, they must be caused by the same agent. This

agent we believe to be the ptomaine produced by the Klebs-Loeffler bacillus.

But a more certain proof is at hand. Loeffler, Bates of Bucharest, and others have produced the typical diphtheritic inflammation in animals, attended by the characteristic pellicle, by means of inoculation with cultures of the bacillus. Further, when the ptomaine is introduced into the circulation of animals, like rabbits and guinea pigs, no pseudo-membrane is produced, but a toxic effect upon the blood—paralysis, which resembles that resulting from diphtheria, and nephritis, accompanied by a form of albuminuria which does not cause dropsy or uræmic poisoning, are produced; and these are the characteristic features of true diphtheria. In the consideration of these facts the mind is irresistibly led to the conclusion that the immediate cause of true diphtheria is the Klebs-Loeffler bacillus and its accompanying ptomaine.

On the other hand, it has been urged that several facts militate against this view. These are, in brief, that the bacillar theory requires that the diphtheritic infection must be first local and then constitutional; that cases occur in which severe constitutional symptoms and even death may occur before the appearance of exudation; that active, early local treatment does not prevent constitutional infection; and finally, that the early occurrence of nephritis indicates primary general infection.

These objections would have weight did they not apply with equal force to other affections. No one can say by what channel the virus of scarlet fever invades the system. How, then, can we state the method or plan of attack of diphtheria, the virus of each disease being equally subtle? The diphtheritic ptomaine may have power of diffusion through the air like other contagia, and, in such case, may enter the system by way of the lungs, as well as by the fauces. If this be true the rapidity with which constitutional symptoms are sometimes produced is explained.

## ● EDITOR'S TABLE. ●

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AT a recent meeting of the Obstetrical Society of Philadelphia Dr. Horace Fox directed attention to the manifest disrelish of medical students for midwifery work, the result being that most of them graduate with a very fair theoretical knowledge of the obstetrical practice of the day, but lamentably weak in its application to a case in hand. Dr. Fox, though apparently a young man, and speaking from the point of view of the junior practitioner, is evidently an earnest worker in this department of medicine. The obstetrical experience which may be obtained among the very poorest of a city's population is of the highest practical value to the undergraduate. For he is here thrown entirely upon his own resources in a class of cases which present more complications and greater deviations from normal labor than he will find among ordinarily thrifty people. If among surroundings totally unhygienic, with none of the conveniences of living, and dealing with people ignorant, perverse, and troublesome in the extreme, he can develop executive ability sufficient to carry the patient to a prompt and satisfactory convalescence, he has learned lessons which will stand him in good stead all his life. It is from this drudgery that students shrink. They are apparently anxious for cases, but after three or four experiences their courage oozes out of them. Dr. Joseph Price, who has charge of the Philadelphia Dispensary says: "It is very difficult to get students to practice obstetrics. I have singled out a hundred men and have assigned them ten or twelve cases, and after they had attended a few they would return and say that they had had enough." Now this is not altogether due to indolence on the part of the student, but rather to the fact that he is sent out to face difficulties which he has not the knowledge to surmount. The teaching in the college halls is too theoretical and begins too late. Obstetrics is acknowledged to be the backbone of practice. To get into a line of remunerative work the young practitioner must do midwifery, and must do it acceptably. Yet in most of the schools

he never sees a case of labor until the third term, and within a few weeks of graduation. Many students graduate with only the knowledge which may be acquired in a compend and from their notes of lectures, but with no actual experience. We are not speaking of things that did exist, but as they are now, in this year of our Lord, 1893. Teachers of obstetrics and preceptors know this, and yet, as a rule, they neglect to give their students that plain counsel as to what they should do, and how they should do it, of which they stand in need. Ten chances to one, the first case to which he is independently called will be one in which the "necessaries," so neatly tabulated in his obstetric compend, will be a minus quality; even a hand-basin, a piece of soap, and a clean towel will be barely obtainable. Not having been told what to do when the "necessaries" are absent, and having been severely coached on that chief of all "necessaries" absolute antisepsis, he gets muddled and does not know what to do. It is to meet just such emergencies that he needs instruction. He will afterward very readily adapt himself to the "niceties" when they are at his command. As to the practical portion of midwifery Dr. Fox says:

"There are many third-year men who do not know how to make a vaginal examination. They enter the vagina wherever their finger finds an opening, and grope around until it by chance strikes the os externum, causing the patient much unnecessary pain and uneasiness. I remember one student who could not enter the vagina at all, but still he made a diagnosis of a vertex presentation and right occipito-anterior position. As to ballottement they are also at a loss when they come to put it to practical use, and I may also state that few know correctly the definition of the word, yet at the same time they pronounce the word with a beautiful correctness and accent. Palpation is to the vast majority quite unnecessary; that is, because they know nothing about it. Never have I found one who did not begin to palpate elsewhere than the superior opening to the excavation. I know that there are a few of the authors who advocate commencing palpation at any portion of the abdomen, and arrive at the diagnosis by synthesis, but the vast majority say to seek the anterior part of the superior strait first, and this I think is taught by all the professors teaching obstetrics in Philadelphia. When it comes

to map out and outline the fetus they use their hands as if they were digging clams. They can talk to you in the most eloquent style how delicacy of touch, etc., should be observed, but practically they know nothing about palpation, nor will they until they have a thorough systematic training on the manikin. In delivering the placenta it has not as yet been my fortune to come across one student who could do so properly. I have repeatedly asked them how they are going to deliver the placenta, and before finishing the question I receive the answer, by the Credé method. Ask them to explain the Credé method, and regularly do I fail to receive the answer. They are all timid about handling the funis. It has been my habit, in demonstrating the delivery of the placenta, to tell them to catch the funis between the index finger and the thumb, and use only sufficient force to make it tense when at the same time they have the fundus in their other hand. My reason for so demonstrating is that, having so little experience, they cannot detect by the hand over the uterus when the placenta has descended; therefore by making the funis tense it will slacken considerably when the placenta has become detached and descended, and they will accordingly know that should it fail to be delivered after the cord has become slackened, it is possibly either in the lower uterine segment or vagina and not adherent. As yet I have had no cause to regret demonstrating the above manuver in conjunction with the Credé method of delivering the placenta."

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ALL practical obstetricians will be interested in the revival of the operation known as symphysiotomy. At least they ought to be, for it bids fair to offer a solution to a difficult problem—how to secure the birth of a child when the pelvic diameter is less than three inches, without sacrificing either mother or babe. Whether it will prove, on the whole, a more satisfactory procedure than "improved Cæsarean section," or than the "Porro operation," remains to be seen, but it has already been successfully applied by Drs. Charles Jewett, of Brooklyn, Baron C. Hirst, and Anna C. Broomhall, both of Philadelphia. It may not, however, be unnecessary to sound a note of caution, to temper the enthusiasm



with which novel remedial measures are so generally received—at first.

The revival of this operation is due to a very earnest and cogent paper, by Dr. Robert P. Harris, which was listened to with deep interest by the members of the American Gynecological Society, at its last meeting in Brooklyn. The title of the paper was "The Remarkable Results of Antiseptic Symphysiotomy."

The author gave the history of the operation from its earliest known time, 1778, up to 1858, when it seemed to have been given up as a recognized means of increasing the diameter of the pelvis. From 1858 to 1865 there is but one case recorded. Later, attention was again directed to it by Belluzi, of Bologna, and since that time it has been performed a large number of times with varying degrees of success. Morisani undoubtedly deserves the credit for the position which the operation now occupies, as he, through many failures, continued to investigate until its technique reached a high degree of perfection. Under aseptic precautions and the improved technique the mortality has been reduced to the lowest degree. A comparison of the early with the late operation will prove interesting reading to the student. In the table prepared by the author there have been forty operations since 1886, with but the death of one woman and three children—dead at time of delivery. Two more children died later, from three to fifty-eight hours. There were four cases of fistulæ (urethro- and vesicovaginal), but in no single case any impairment of locomotion. A pelvic diameter of  $2\frac{1}{4}$  inches is the safer minimum limit for the operation, more so than Morisani's of  $2\frac{3}{8}$ . The safe average separation of the seat of operation is  $2\frac{1}{2}$  inches. The method of performing the operation, after the part has been shaved and everything made aseptic: a catheter is introduced, by which the urethra is depressed and carried to the right. Then a vertical incision is made about  $2\frac{1}{2}$  to 3 inches through the skin and fat, going to the left in order to avoid the clitoris, detaching the muscles for a short space; introduce the finger and separate the tissues behind the bone, and locate the finger (left hand) on the inferior margin of the articulation. Then, introducing the knife (Galbaiti's), cut from within outward and upward. Care must be observed during the passage of the child to keep the parts cov-

ered and free from contamination. Aseptic dressing and confinement to bed until union takes place complete the operation.

The results detailed in the paper were so remarkable and so unexpected that probably most of the listeners would have carried away with them a feeling of almost incredulity as to its practical value had not Dr. Lusk supported the conclusions of the author with all the weight of his authority as a distinguished teacher in operative midwifery. This, and the successful application of the method by Dr. Jewett a few days later has, as it were, set it upon its feet as an available method. As Dr. Ernest W. Cushing, of Boston, says :

"It is a solemn thought that of 84,000 already overloaded obstetric bags in this country, a very large proportion is to be enriched by the acquisition of a hooked knife for symphysiotomy, a weapon that will prove a sickle of death, unless guided by intelligence, environed by cleanliness, and illuminated by anatomical knowledge. Like any other operation, pubic section is easy and safe enough for a surgeon who is clean and careful, and whose patient is in reasonably good condition ; but the incision goes near important organs—the urethra, the bladder, and the peritoneum ; it passes where there may be hemorrhage from arterial branches, which must be looked for and controlled ; it lays open important cellular spaces, which must be kept clean, and it sunders the key to the ring of the pelvic bones, so that care must be taken that no undue violence is done in the subsequent delivery. If attention be given to these facts, the new operation promises to be a splendid advance in our art, a means of rescuing great numbers of women, sinking under the throes of prolonged and hopeless labor, and of saving the lives of innumerable innocent infants, now permitted to perish undelivered, or sacrificed in the stern choice between losing two lives or taking one."

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**S**PECIALISM in medicine enables a man to acquire facility in operative procedure, but it should not be overlooked that it has a strong tendency to narrow his vision as to medicine in general. This is so well understood that even the laity remark, with some show of truth, that if one goes to an oculist he is sure to find

some trouble with the patient's eyes. Many of the greatest specialists, and they are great for this very reason, keep themselves in touch with the general progress of the medical art, and so escape the narrowing tendency of their own immediate work. It is especially desirable that gynecologists should do this. For whatever affects any part of the woman's physique will, through the great sympathetic system, affect reflexly the ovaries and womb. It is not uncommon to meet cases that have been treated for long periods of time for uterine disease, in which no disease of the uterus or of its appendages existed, or ever had existed.

One of the more common causes of these mistakes in diagnosis is disease in the rectum. The anatomical relation of the rectum to the uterus is probably the most important factor in this simulation. The blood vessels and nerves which supply the rectum, and those which are distributed to the ovaries and uterus, are so intimately related that disturbance in one organ is apt to be communicated to the other; and the intensity of sensation may be greatest in the organ which is merely sympathetically disturbed. As for instance, women quite frequently complain of pain on the left side of the pelvis, and this is usually diagnosed as indicative of trouble in the left ovary; but it is not infrequently due to constipation and repeated straining at stool. The chief reason for this is the anatomical relation existing between a distended rectum and the left broad ligament and ovary. Distention, relaxation, and congestion in the colon and rectum will make, in the lapse of time, an inimical impression on the pelvic viscera. On the other hand, a chronic inflammation of the generative organs is quite as frequently complicated with hemorrhoids and fissure of the anus.

If we take account of the great amount of force expended in evacuating hardened feces it will be readily perceived that straining at stool is a very common cause of uterine dislocations. In no natural use of muscular exertion can so great a downward force be applied to the uterus as in the attempt to extrude fecal matter which has lain in the rectum until the moisture is all dried out of it. Lifting, moving heavy furniture, running a sewing machine constantly, standing before a hot range all day cooking, even complete laceration of the perineum, are not sufficient to cause

displacement when the bowels move normally, regularly, and efficiently. "But when," as says Dr. Gill Wylie, "the levator ani is torn through, and the lower end of the rectum, thus losing its support, is pushed forward by the fecal matter, it tends to push the vagina out of the body; and anything which pushes or pulls down on the posterior wall of the vagina must also pull on the cervix, displacing it downward and forward."

In making vaginal examinations it is sometimes found that acute pain is caused when making pressure upon the posterior wall. This is due to a hyperæsthetic state of the mucous membrane of the rectum at a distance above the sphincter. This most frequently occurs in connection with fissures of the anus, or with hemorrhoids, but may be present when these are not. This class of cases is, in allopathic hands, subjected to courses of douching, the local application of caustics, and to scraping with the curette, but under careful homeopathic treatment yields quickly without any of these harsh measures. To those who have not had hoped for success in the medicinal treatment of this trouble we would recommend a study of Dr. Guernsey's little book on Hemorrhoids, in which many serviceable hints may be found. Fissure of the anus and hemorrhoids may be cured in the same sensible way. Doubtless the local trouble may not infrequently be quickly remedied by operation. We do not deny the value of surgery in these cases. But, almost always, the general health of the patient is very much run down, and the symptoms in the case afford ample means for selecting the remedy which will cure the local hyperæsthesia, the hemorrhoids, the uterine dislocation, as well as the more general symptoms from which the patient is suffering.

Backache is often looked upon as evidence of uterine disorder, and perhaps the poor woman is treated for months with no relief, when a more careful study of the case would have shown that the trouble is simply rheumatic or neuralgic. Pain in the side is often due to prolapse of the kidney. If the kidney is anteverted the ureter will probably become partly occluded, and the free escape of the urine will be prevented. The urine is thus damned back into the pelvis of the kidney and causes a peculiar aching, or at times a spasmodic pain. Distress in the right side might also be

caused by typhlitis, and a mistaken diagnosis made of ovarian disease.

In calling attention thus to various troubles which may be mistakenly diagnosed as uterine or ovarian in origin—and we have not mentioned a quarter part of them—our purpose is only to reinforce the old lesson taught by the fathers of homeopathy that it is essential to proper treatment that in the beginning we fully and carefully “take the case.” In the rush of practice we are too apt to jump at conclusions. It is difficult to patiently inquire into the condition of all the associated organs when a woman presents herself for “uterine treatment,” and the bell keeps announcing that more and more clients are waiting in the reception room. But unless we do so we cannot be even reasonably sure of making a correct prescription.

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THE American Obstetrical Society at its annual meeting on December 15 elected the following officers for the ensuing year : President, Prof. John Nicholas Mitchell, M. D., Philadelphia ; vice presidents, J. B. Gregg Custis, M. D., Washington, D. C., Prof. George R. Southwick, M. D., Boston, and Prof. Sheldon Leavitt, M. D., Chicago ; secretary, George William Winterburn, M. D., New York ; treasurer, A. Leonard Chatterton, Brooklyn, N. Y. ; Censors, Thomas Franklin Smith, M. D., New York, Mary A. Brinkman, M. D., New York, Clarence Willard Butler, M. D., Monclair, N. J. The papers read at the meeting, and the discussions thereon, will appear in the JOURNAL. A number of new members were elected, and the society is in an altogether prosperous condition. The membership fee being only nominal (one dollar), all homeopathic physicians practicing midwifery should become members. The application may be sent to the secretary, Dr. G. W. Winterburn, No. 230 West 132d Street, New York, or to the chairman of the Board of censors, No. 264 Lenox Avenue, New York. The next meeting of the society will be in Chicago, on June 1, 1893.

THE editor desires to return thanks to the numerous subscribers to the JOURNAL who have taken a kindly interest in his new magazine for parents—*Childhood*. He would be indeed insensible if he did not feel deeply the many evidences of goodwill which have come to him.

## ● GOLDEN GRAINS. ●

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—PROF. LUDLAM had in his clinic recently a case in which on introducing the uterine sound it passed its whole length so that only the tip of the handle could be seen. In commenting upon this he said : “ Some years ago I was sent for in consultation by one of our best physicians who had stumbled upon just such a case as this. With a view of measuring the depth of the uterus and to learn if it were displaced, he had passed the sound very carefully in a patient who had never had it passed before, when to his amazement the instrument kept on its course until he thought he should lose it altogether. Fearing that he had perforated the womb and might have caused a fatal peritonitis, he sent for me to share the responsibility and to explain the mishap. I found the patient comfortable and smiling, passed the sound as I have done for you, gave the doctor a short lecture on regional anatomy, took my fee, and departed. But where is the point of this sound, and how shall we explain its passing to so great a depth when the uterus is not enlarged and we know that we have not done any mischief ? The only explanation of the fact, for it is a fact, is that it must have passed through the internal orifice of the fallopian tube. But in order that this should happen, three things are requisite : (1) the uterus must have so deviated in its perpendicular axis as that one of its cornua shall be brought toward the mesial line of the abdomen ; (2) that the tube shall have been displaced upward so as to lie parallel, or nearly so, with the linea alba ; (3) that the ostium internum of the tube shall be patent.”

—THE uterus may be displaced laterally as well as in other directions. Not only this, but the appendages may assume strange positions with relation to the other pelvic viscera. Thus it comes about that with the uterus a fallopian tube may form an open conduit. It is not safe, however, to assert, because the sound passes easily and without force its whole length into the uterine cavity, that, therefore, the tube is patent. It may well be

that through frequent examinations a fistula has been formed, by careless manipulation, and that the point of the sound is in the abdominal cavity. It is easy, however, to determine this latter fact, provided the omentum be not too gross.

—DR. S. M. CARRIGAN reports a very peculiar case (*Jour. Ark. Med. Soc.*) of hemorrhage ten days after delivery. The labor had been easy, requiring, however, the use of forceps in the last stage; the placenta firmly adherent to the fundus of the uterus, but delivered whole. The patient had been given a daily douche of carbolyzed water, and did well until the tenth day, when she had a hemorrhage, followed on the eleventh by another profuse one, which could only be controlled by tampons of gauze. The bleeding was stopped, and the next morning the gauze was removed, leaving the uterus firmly contracted. When the obstetrician learns the risk of using carbolic solutions after delivery, cases such as these will be less frequent.

—DR. ROBERT H. M. DAWBARN reports in the *Medical Record* three new cases treated by saline injections under the new technique. These cases are of particular interest as proving the usefulness of this method of supplying the system with a volume of fluid to replace that lost through hemorrhage. The technique is simple but important. The fluid used is hot water, 120°, to which is added salt (six parts to a thousand of water). The use of the salt is imperative, as pure water will at once dissolve out the hemoglobin from the blood. A double dish is used, the first to contain the solution for injection and the second, in which it rests, to contain water hot enough to keep the solution up to the proper temperature, and a Davidson syringe, to which is attached the needle of a hypodermic syringe. The needle is introduced at right angles into the lumen of the femoral artery, its presence there doing no harm, and the flowing of bright red blood through the needle proves it to be in the right place. The needle is now connected with the syringe, and the solution slowly introduced. It requires about half an hour to inject a pint, which is enough at one time for the artery. It is well, however, to push in a pint or two more, distributed around over the legs and abdomen. The fault gener-

ally lies with the small amount injected. Two quarts is about the right amount, and if more is thrown in it can do no harm.

—DR. EDWARD P. DAVIS reports a case of retroperitoneal tuberculosis simulating hernia. The patient was a young woman employed as a domestic, who, after lifting a heavy weight, complained of pain in the right inguinal region. She was confined to her bed for eleven weeks with metrorrhagia as a complication. Recovered and went to work ; afterward was taken with severe pain in the right ovarian region. At the time she came under the care of Dr. Davis, she had a temperature of  $102^{\circ}$ , with rapid pulse. The history was good, although her father died of tuberculosis. A hard swelling existed in the right inguinal region. This was cut down upon and attempt made to reduce it, which failed. The condition of the patient at this time was such as to cause alarm. The abdomen was opened in the median line with the result of the discharge of a quantity of pus. There was nothing found to give cause for the abscess. No tubercle bacilli were found.

—DR. WILLIAM F. LUSK reports two cases in which there was great similarity in both objective and subjective symptoms. One was a calcified fibroid, which had existed for several years. The other was a lithopædion of thirteen years' duration. In this latter case at the time of pregnancy, thirteen years before the removal of the calcified fetus, she had been attacked with labor pains, which subsided and left the fetus in the abdomen.

—In commenting on multiple pregnancy, Dr. Joseph Price says : "I remember one case very well ; a patient whom I had assigned to a Jefferson student. After watching the case all day, he came to me about eight o'clock and said that something was wrong, that the woman was full of fetal heart sounds and full of baby. I went with him and recognized two fetal heart sounds. I made him puncture the membranes, and in a short time, he delivered a large child, which he carried downstairs to the old colored woman in charge. When he came back the second child was presenting. The second membranes were punctured and the child delivered. This was carried downstairs. He came back, and on examina-



tion said that a third was present. He then delivered a third child."

—*LAC CANINUM* will sometimes restore the flow of milk when it has suddenly stopped ; but it is not applicable in those cases where fright was the characteristic indication.

—*IN* neuralgic dysmenorhea, *zanthoxylum*, in the medium potencies, is singularly efficient. It will prove most useful in thin, delicate women. The discharge is usually profuse.

—*Cutaneous* geromorphism is a term used by Charcot to designate a peculiar disorder which makes a young person look as if aged. He describes a case of a woman whose age was twenty-one years but whose physiognomy was that of seventy years. Her apparent senility was so striking that her father, aged fifty-two, had occasionally been asked if she was not his mother. The pathology is limited to the skin, especially on the surface, and is a "decrepitude of the cutaneous system." Otherwise the girl had nothing old-appearing about her. Her hair was blond and of average length. Her intelligence was good, her memory precise, and her judgment reasonable, but she was readily frightened when in a crowd or by noises ; her emotional nature was fairly well balanced, but she was despondent on account of her appearance of age, which she had come to believe was incurable ; and the slightest indisposition begot a fear of death. Her cutaneous sensibility was normal. The special senses of smell, taste, and hearing were normal. There was a slight impairment of vision, without contraction of the visual field or color-blindness ; there was no arcus senilis. The hepatic, renal, and uterine functions appeared to be normally performed ; a slight leucorrhœa had existed for two years. The wrinkling had begun about ten years before, at which time she received a great fright. She was then a bright, joyous child, very pretty and refined in her appearance, and always in the lead of her classes at school. When the change in the skin began, there was, for a short time, the formation of pimples, which persisted a few days and then disappeared without ulceration or mark of any kind. There was no œdema of the cutaneous surface. The wrinkling changes took place so rapidly that, it is stated, her friends were unable to recognize her

if they had not seen her within the period of a fortnight ; the skin at that time is described as resembling "the scales of a fish." No form of treatment, whether by electricity, hydropathy, or tonics, has been competent to improve her condition ; but it would seem as if hydrocotyle, in medium potency, perhaps aided by an occasional dose of opium, in a high potency, should have cured this case.

—In a case of obstinate constipation during pregnancy, which had continued for several months, the patient having to sit for an hour before she could extrude a few hard round balls, plumbum 12 cured. The next day after taking the medicine she had an easy natural evacuation, and so continued up to the time of labor.—*Dr. Lamb in Hom. Rev.*

—Exact abdominal diagnosis is an impossibility, and he who asserts to the contrary is either rash or inexperienced.—*Lawson Tait.*

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## NOTES ON CURRENT LITERATURE.

### AMERICAN SURGERY.

THERE is so much to commend in the new volume on surgery which has been recently issued by W. B. Saunders, of Philadelphia, that it is difficult to decide as to what might well be mentioned first.<sup>1</sup> We have had many encyclopedic works on medicine and surgery, but this one has been constructed on a novel plan. Each article is, of course, written by some one man. But it is then submitted to all the others, whose names appear on the title page of the volume, for revision. In this way each page of the work has the direct indorsement of a dozen of the best equipped surgeons in the world.

No one need be told that surgical manipulations have greatly changed during the past few years. Whether all the changes have

<sup>1</sup> AN AMERICAN TEXT-BOOK OF SURGERY. For Practitioners and Students. By Drs. CHARLES H. BURNETT, PHINEAS S. CONNER, FREDERIC S. DENNIS, WILLIAM W. KEEN, CHARLES B. NANCREDÉ, ROSWELL PARK, LEWIS S. PILCHER, NICHOLAS SENN, FRANCIS J. SHEPHERD, LEWIS A. STIMSON, WILLIAM THOMAS, J. COLLINS WARREN, J. WILLIAM WHITE. Edited by WILLIAM W. KEEN, M. D., LL. D., and J. WILLIAM WHITE, M. D., Ph. D. Illustrated by 37 plates, and 473 wood engravings. Royal 8vo, pp. 1209. (Philadelphia : W. B. Saunders, 1892.)

been advances may well be doubted. The strong competition of modern life creates the desire on the part of many an operator to strike out on some novel path in order that he may attract attention to his work and so lift himself into prominence. In addition to this the spirit of the age is unrestful, and we all of us share to some extent in this craving after new things, and admiration for new methods, which dominate our time. But whether a change in methods is an advance or not, it is necessary that all practitioners of the art should keep themselves in touch with the movement, for out of the change will proceed good, if in nothing more than in re-establishing the older methods the more firmly. The work, therefore, of Drs. Keen and White, and their associates, was a needed one, and well deserves appreciation. It bears everywhere the marks of high scholarship. It covers the whole domain of modern surgery. Necessarily compressing so much into one volume, there is no waste of space and the language is terse and direct. And yet if one takes up any particular subject, as for instance fractures of the leg, he will find that what has been said covers every necessary detail. The illustrations also are, in the main, modern and original, many of them being strikingly instructive. In no particular have medical works improved to such a degree as in illustrations since photography came to its aid. The teachings of the whole work are pre-eminently American, and it may most heartily be commended to the student and the practitioner.

#### BONE TUBERCULOSIS.

THE pathological problems of joints affected with chronic disease have not yet been all solved, but a great advance has been made during the past two decades. In fact, it is hardly so much an advance as a revolution. It has come now to be understood that chronic joint disease means usually tuberculosis. Just when a joint, unsound from sprain or other injury, ceases to be simply a traumatic joint and becomes a tubercular one does not yet appear. Neither is the relationship quite clear which seems to exist between joint disease in the children of tubercular parents, tubercular joint disease in the children of syphilitic parents, and joint disease unquestionably due to hereditary syphilis. For while, when a joint is opened out, either by excision or after death, the tubercle bacillus is found in nearly all cases of joint disease, it cannot be said to be definitely determined that the lesion is tubercular. Pathogenetic germs have a tendency toward diseased parts, and may be found there when there is no other evidence of their connection with the disease. Thus in the mouths of persons who fail to keep their teeth clean,

or who have carious teeth, a great variety of pathognomonic bacteria exists in multitudinous profusion, without any corresponding lesion.

Among surgeons who have given particular attention to the subject of the pathology and treatment of joint disease, Prof. Nicholas Senn, of Chicago, stands pre-eminent. In his recent work on this subject<sup>3</sup> he shows what a common affection tuberculosis of the bones and joints is, and urges the necessity of early diagnosis, before the disease has become incurable. It is just here, in the uncertain stage, when an absolute diagnosis of tuberculosis is impossible, that homeopathy can do much. Prof. Hel-muth, in a recent clinic, showed how much a wise use of medicine can accomplish in children suffering from joint disease presumably tubercular.

Although most of these cases are on the borderland of tubercle, or have passed within its domain, we still prefer to retain the term, chronic joint disease. It calls up a familiar picture, and, whatever may have been its initial causes, demands, as a rule, much the same treatment. While speculation upon the precise pathological changes which have gone on in the joint presenting itself for treatment is interesting, and perchance useful, yet the main question with the physician is how he may treat the disease, and restore the joint to usefulness. Prof. Senn's work will teach him much that it is necessary he should know—the mechanical part, and the surgery of the joint. But beyond this in clinical importance is that vast storehouse of the homeopathic materia medica which he cannot neglect in justice to his patient. This is the true conservative surgery; which neither ignores mechanics nor the bistoury and the saw, but which never resorts to these through ignorance of the resources of the materia medica.

THE leading feature of the *North American Review* for October is a paper from Gladstone, "A Vindication of Home Rule." Following this is a striking array of articles from the most brilliant pens. Mr. Labouchere contributes one on "The Foreign Policy of England," and Prof. Lockwood one on "The Hygiene of the Atmosphere." The sparkling criticisms of Lady Jeune appear in another one of her "London Sociey" articles. We do not recollect a better number than this one of this always excellent Review.

<sup>3</sup> TUBERCULOSIS OF BONES AND JOINTS. By N. SENN, M. D., Ph. D. Illustrated with 107 engravings (seven colored), royal 8vo, pp. 520. (Philadelphia: The F. A. Davis Co., 1231 Filbert Street, 1892.)

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

## NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal should be exclusively for its pages.
2. For the convenience of subscribers, this journal will not be discontinued until so ordered.

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## LAPAROTOMY FOR THE RELIEF OF INSANITY.

BY

SCOTT B. PARSONS, M. D.,

St. Louis, Mo.

THERE is so little literature on the subject of abdominal section for the relief of mental diseases that it is difficult to form any estimate of the frequency with which it has been performed or the value of surgical procedure as a mode of cure for derangements of the mind. A large number of gynecologists seem directly opposed to the use of such a method, and yet their antagonism is based, not upon the unsuccessful results following removal of the uterine appendages, but more from the standpoint of the neurologist who claims that although the mental disturbance may be of a reflex character, there are modes of treatment, as galvanism, douching, local applications, as well as internal medicines, that are not only safer but also surer.

I take it for granted that little need be said at this time on the ætiological relations of diseases of the brain and sexual organs. No one will dispute the fact that insanity is often observed as a result of diseases of the generative

organs. A close analysis of quite a number of cases has led me to firmly believe that diseases of the uterus, ovaries, and fallopian tubes are no small factors in producing and maintaining many of the frequent cases of insanity which are met with in everyday practice.

As physicians, we are too apt to consider mental affections as abnormal states which should be assigned to the neurologist without further consideration than that they are nervous affections and properly belong to his category. This, I feel, is often a sad mistake, and a great wrong to the patient. Many a poor mother has been forcibly separated from her home and family and thrust within the prison walls of an insane asylum, and there held in bondage for months and years, when a close and careful investigation of her case by her family physician might have saved her the disgrace of an incarcerated lunatic as well as the long, weary weeks of physical and mental suffering, and restored her as a well woman to her friends and family.

Manifestations of mental incompetency are not always the signal lights of cerebral structural changes, any more than flutterings, palpitations, and other circulatory disturbances are necessarily dependent upon organic cardiac lesions. Yet a continuous and persistent reflex exciting force upon an organ may eventually induce changes that will not pass away after the primal disease has been removed. Every organ is capable of excitation by centric and eccentric impressions, and I concede the question that it is often difficult and perhaps an impossibility to differentiate cases of reflex neuroses from those of direct origin. But the number of uncertain cases is small in comparison with those whose causative forces are easily determined.

The complex construction of the brain harmonizes with the complex construction of the external organs, and pathological conditions of each individual cerebral nerve center will manifest themselves by extrinsic signs, and conversely, peripheral irritation, more particularly when seated

in those organs presided over by the sympathetic nerve system, will produce responsive action in the brain cells. There is no organ or set of organs that more quickly affect the brain than the generative organs of women when diseased, and no organs that excite a greater diversity of mental states.

It is a matter of daily occurrence to meet with women whose mental condition is the great source of trouble to their friends, and which overshadows all other symptoms by its prominence. And yet other indications of equal importance are present, but modified or hidden by the abnormal mental state. Such cases are liable to mislead the physician for the reason that all the symptoms of bodily affections are obscured by the deranged condition of the mind. The history of such cases is nearly always one of frequent childbearing, hard labor, or miscarriages in which more or less violence has been done the procreative organs, and a careful investigation will reveal the fact that an injury has been done to these organs which thus far has been undiscovered, and the morbid mental action is a visible mode adopted by nature to warn us of the patient's serious condition.

In my list of surgical operations are enumerated six of this class of cases. Three were Germans, two Americans, and one English. Two were for acute mania, one for chronic mania, two for melancholia, and one for nymphomania, their ages ranging from twenty-eight to fifty-six years. All had been married but one, and each but one had borne more than one child. The results were perfectly successful in four cases, the two of acute mania and two of melancholia, while the case of chronic mania improved only in general health, and no benefit whatever in the case of the nymphomaniac, the last being operated upon only to satisfy the relatives, who been advised to have the ovaries removed. In four both ovaries and both tubes were taken away, and in two one ovary and tube only was amputated.

I have thought it might not be uninteresting to relate some of the cases to show how profoundly pathological conditions of the generative organs will exert their forces upon the brain and how quickly recovery will follow their removal. The first is a case of melancholia, and the second one of acute mania.

CASE I. Mrs. D., German, æt. thirty-three, married, mother of five children, the youngest being twenty-one months old. No miscarriages; had a poor "get up" after her last labor and suffered a great deal of pain in the pelvic region for many months subsequent to her confinement. The flow continued for some weeks and kept her in an exhausted state, so much so that she was unable to attend to her household duties for three months. Her digestion was bad, no appetite, was sleepless, and had nightly visions that frightened her. They appeared to her when awake at night and eventually came in the daytime. Her mind became depressed to such an extent that she neglected her family and would sit and stare into vacancy for hours at a time. Nothing seemed to rouse her, nor please her, nor cheer her. She could not be made interested in anything, not even in her family, which she had hitherto been very fond of. Her disposition was naturally mild and hopeful, and previous to her present trouble she had always been bright and animated. She would get up from bed at night and wander apparently aimlessly about the house, and even go out of doors in her night clothes if not prevented. She had expressed a desire to die, and sought to commit suicide by cutting her throat on the inside with a pair of scissors and at another time by smothering herself with a feather bed, but her faithful watchers were ever on the alert and at every turn to do herself harm she was quickly checked. It had been such an arduous task to take care of her that the question of sending her to an insane asylum was under consideration when I was called to see her. If she ever complained of her head or was asked where it hurt her, she would invariably place her hand upon the vertex.



Upon examination I found her anæmic, thin, having lost twenty-seven pounds since the birth of her child, mucous membrane pallid, rather inclined to be quiet while I talked to her, although she kept her hands and fingers moving continuously and would not answer questions until they were forcibly and directly applied to her, and then only in monosyllables or very short answers. A vaginal examination revealed the uterus slightly larger than normal, a slightly lacerated cervix, and both fallopian tubes and ovaries enlarged and quite tender to the touch. While manipulating these organs I found that heavy pressure upon them roused her into an unwonted activity. She would twist and turn and talk in a sort of half rambling manner, and at another time said that "every pushing went straight to her head." The left ovary could be distinctly felt lying in Douglas' sac and was exquisitely tender to pressure. At every examination, whenever I made severe pressure upon the left ovary and tube it was invariably followed by twisting and turning and the same semi-incoherent jabbering, which ceased as soon as I withdrew my hand. This result I could produce just as often as I applied sufficient force. The physician who had attended through her confinement and for a long time afterwards, considered it a "case of perpetual mania," but what was its cause he could not say. His treatment had been the usual old school remedies and adjuvants, but he had relied largely upon brom. of potash and comim. without the least effect. After a week or more of observation I expressed the opinion that her mental state was due to a reflex irritation, probably from the pelvic region and more definitely from the uterine appendages, and that in my mind their removal was demanded. From the indications presented I felt morally certain that they were large factors in the causation of her malady. To the proposition that an operation be performed they readily assented, and after a few days of preparatory treatment I removed both ovaries and tubes, by laparotomy, on the

27th day of January, 1891. The left ovary was larger than the right one, measuring  $3\frac{1}{4}$  inches in length by  $1\frac{1}{4}$  inches in diameter. It was adherent to the pelvic floor, from which it was detached easily as the adhesions were not very strong. Both ovaries were in a state of cystic degeneration. The right tube was larger than the left one, being  $1\frac{1}{2}$  inches in thickness by  $3\frac{1}{4}$  inches in length, very dark red, and so friable that it broke when the ligature was tied around it. The right tube had a pus pocket; the left one did not contain pus. She rallied from the operation very quickly and passed through the traumatic period without an unfavorable feature. Her highest temperature was  $101\frac{1}{4}$  on the evening of the day of the operation, but never reached 100 after that time. On the twelfth day she was strong enough to sit up in a chair, and left her room on the sixteenth day.

There was no perceptible change in her mental state till about the eleventh day, when she began to ask for more food. Up to this time her diet consisted of milk and broths. Now that there was a demand for stronger food, meats, vegetables, and fruits were given sparingly twice a day, which seemed to strengthen her wonderfully, and as she increased in bodily strength, so also did her mind improve. Her sleep became more quiet and prolonged, while hitherto it had been fitful and restless even long before the operation. Her conversation also became more rational. She took more interest in herself and things going on around her, often spoke of her home and family, and expressed frequent desires to see them again. It had been deemed advisable to keep every member of her family from her presence during the time of her stay in the hospital, as it was noticeable after the first few days that their visits would excite her at one time, and then again she would not notice them nor speak to them. Her face slowly lost its wild look, and the quiet, peaceful expression of cerebral calm gradually settled in its place. For three or four weeks

she would occasionally have irrational spells lasting for a few hours, but the intervals grew longer and the periods of excitement finally entirely disappeared. She returned to her home on the 12th day of March, having been under my treatment forty-seven days, with her mind quite restored to its normal condition. On February 17, 1892, she writes: "I am in perfect health both of mind and body. My head never troubles me now."

CASE II. Annie S., German, æt. thirty-four; unmarried; came under my care on the 14th day of February, 1890. She had been unfortunate in her matrimonial efforts, and six months previous gave birth to a child as a result of misplaced confidence. She had a hard time, the child being removed by instruments after a lingering labor. She had not seen a well day from about the first week of pregnancy to the time I first saw her. During her pregnancy, or about the middle of it, her friends noticed she acted strangely, became sleepless, nervous; the slightest noise or sudden appearance of anyone coming upon her unawares would cause her to start with fright. Her face gradually assumed a wild appearance, her conversation became erratic and at times very rapid, and then again she was morose, sullen, and would not answer or speak. Slowly her mind became imbued with the idea that everybody was her enemy, and if in her wild moments anyone tried to approach her, she would pick up a chair or anything she could get hold of to defend herself and drive them away. She seemed to grow worse as the time of parturition approached. At the time of confinement it required close watching and no little force to manage her in the first stage. In the second stage she was more quiet, but no more rational. For two or three weeks afterward she lay in bed very still, though there were frequent turns of irrational and loud talking, with some strange gestures of the hands, as if pointing to an imaginary object. This condition varied but little up to the time I made my first visit. When I entered the room where she

was sitting, she quickly rose from her chair and stood staring at me for some moments without moving or speaking. I spoke to her, but she gave no answer in return. Her eyes were fixed upon my face and did not turn from it until I had nearly reached her with my hand extended as in the act of shaking hands. She then darted across the room, and, turning, stood and stared at me again like a stag at bay. I took a seat and talked with other members of the family, occasionally addressing her. After a while her fear gave way and she allowed me to sit beside her. I found she would talk with reason for some few sentences, then wander off into the vagaries of a diseased mind. At each visit I gained a little more of her confidence, and slowly drew out of her many things of great value from a diagnostic point of view, although they were first hinted to me by her friends. The change in her mind came on two or three months after a number of attempts, both medicinal and instrumental, had been made to produce an abortion, at which time, and in fact until she became insane, she had almost constantly severe pelvic pains.

After visiting her for a week, at the urgent solicitation of her friends as well as myself, she allowed me to make a digital examination. The moment I made pressure upon the right fallopian tube, which I found enlarged and tender, she screamed and almost threw herself away from me. Further investigation revealed a prolapsed right ovary and evidences of peritoneal exudation. There was still some metrorrhagic flow, which had continued off and on since childbirth at irregular intervals. There was also a bicervical laceration, with erosion. The uterus was somewhat larger than normal, but only to a slight degree.

Previous to her becoming pregnant she had always been in good health, menstruation regular and never painful, nor had she ever had pelvic troubles of any kind, and her mental status was unquestionable. After reviewing the case I concluded that her mental affliction was due to some trauma-

tism of the uterus or its appendages, or both. I could not feel that the mental state was the outcome of a failure to hide her shame by aborting, nor that it was due to gestation, as parturition should have been a mode of relief for both. And again, the change in her mind came on two to three months after severe pelvic pain following futile attempts at abortion. Taking these facts into consideration, I advised an operation for the removal of the right and possibly the left ovary and tube, with the understanding that the results might be nil so far as healing the wounded mind was concerned, but I believed that much good would follow the operation. Consent being given, on the 8th of March I opened the abdominal cavity and removed the right ovary and tube with great difficulty. The ovary lay in Douglas' sac, firmly adherent to the pelvic floor. The tube was very much enlarged and elongated, and fastened to the pelvic wall by peritoneal exudates. The left ovary and tube were not perfectly normal, but were in such a condition that their removal was considered unnecessary.

Immediately following the operation came a change in this respect, that she became quiet in her movements, lay perfectly still, did not throw herself about the bed as before; but the melancholia and the occasional spells of great excitement continued without any signs of abatement till in the early part of April, about one month later. We then noticed that the habit of not noticing visitors when they came to see her was not so marked, that she would answer questions more readily, was less nervous and irritable, and the facial expression manifested more intelligence. These changes for the better steadily continued, but very slowly, and it was a matter of some months before her mental vigor was fully restored.

In the first instance it might be a question whether the cerebral symptoms were due to reflex action or from nervous exhaustion and malnutrition, as her mental state did not appear to improve until she was put upon a good, nourish-

ing diet. If the latter was the direct cause, may we not fairly assume that uterine injury was the indirect influence necessitating surgical measures as a mode of relief, and does not the happy issue confirm this theory?

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## PULSATILLA.

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BY

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**T**HIS ancient legendary flower, anemone, the Latins tell us, was a nymph beloved by Zephyr, and, therefore, banished from her court by the jealous Flora and changed into a cold spring-flower; when, later, having received with coldness the attentions of Boreas, who, on that account, "maliciously continued them until she slightly opened her petals, when he blew a cold blast which caused the tender flower to fade away."

This classic wind flower, in these days of scientific investigation, has, in the hands of the homeopath, become a most potent remedy.

It is of especial benefit to the gentle, pale-faced, blue-eyed, laughing, weeping, sprightly, mischievous female, or the somewhat effeminate male.

It is of benefit in the troubles arising from the use of fats; from fright or mortification; rheumatic and arthritic affections; swelling of the joints; erratic gout; drawing pains, lancinating in the muscles of the extremities; rapidly shifting pains from one part of the body to another; pains and ailments of one side of the body; pains, with chilliness; extreme weakness, with bruised feeling of the limbs; heaviness of the whole body; fainting turns, with pale, cadaverous face; pains from remaining long in one position, relieved by

change or motion ; pains aggravated at night in bed ; emaciation. It exerts a strong influence upon the veins.

In its action upon the skin we have biting, itching, hot, red spots, like nettle rash ; eruptions, like varicella ; erysipelas, with swelling ; blue, hard swellings ; useful in measles and their secondary affections ; in flat, putrid ulcers ; some forms of eczema. Verified in practice as follows :

Mrs. Y., æt. twenty-eight, in the Treasury Department at Washington, D. C., had been under treatment (old school) at Washington, at Albany and Buffalo, N. Y., two years. She presented a case of eczema squamosum. There was a large denuded surface, including large patches, above each knee and the calf of each leg. The exudation was so profuse that she constantly wore oil silk inside her stockings. Without it the drip was so great as to wet the floor where she sat. The retention of the moisture by the silk may, in a measure, have accounted for the peculiar appearance, for while the corium was denuded and red, there were large patches which looked as if the epidermis was partly detached and floating on the fluid. The biting itching was at times distressing.

A prominent symptom in the case was scant, irregular, imperfect menstruation. Pulsatilla 6th was given without apparent effect, followed by puls. 12th, with marked aggravation of the skin disease. Ten days or two weeks later, at the next call, she was so despondent that she wished for something to end her days, if she could not be helped. I assured her that an aggravation was often the precursor of a cure. Prescribed puls. 30th, which was in a few days followed by profuse menstruation and an entire disappearance of the eczema, which a year later had not returned.

Under the head of sleeplessness mention should be made of restlessness during sleep, with frequent waking ; sleep full of dreams—frightful, anxious dreams ; starting and crying out ; sleep prevented by a constant rush of thought.

It is of value in fever when there is coldness and shiver-

ing ; feeling of chilliness, with vertigo and pain in the head ; with heaviness, anxiety, and oppression of the chest ; during high fever, with red, bloated face ; chilliness when undressing, on moving the covering of the bed, or on turning at night in bed. The apyrexia is generally characterized by headache, painful oppression of the chest, moist cough, somnolence, bitter mouth, diarrhea. In hectic, pulse quick, small, almost collapsed ; disposed to sweating during day ; profuse sweat in the morning.

Under moral symptoms should be mentioned melancholy and gloominess ; sad and weeping, silent mood ; great solicitude about one's health ; excessive irresolution ; peevishness ; hypochondria. Patient is disgusted with everything. Illustrated in the case of Mr. H. : Father and one brother in the asylum for the insane. This patient was somewhat ill from overwork upon his farm. He became oppressed with a sense of weakness ; work became repugnant to him ; he could maintain no fixed purpose ; he was vacillating, unstable ; could not oversee and direct his men ; would attempt to do so and then soon walk off and leave them to manage for themselves ; would commence something else, but would soon leave that also ; complained of loss of appetite and of weakness, especially of weakness of the lower limbs. After several seemingly indicated remedies had been tried until his friends feared he would soon be in the asylum with his father and brother, he was finally put upon puls. 6th, making a reasonably rapid recovery.

The head symptoms are : heaviness of the head ; hemi-crania, as if the head would burst ; aching pain in the head when stooping ; lancinating pain in one side of the head, teeth, and ear ; headache from long watching.

It is very restless in weariness from long care of the sick, often making the watcher your friend and a believer in your medicine ; headache, as from overloading the stomach, or from fat meats, or from pastries.

Pulsatilla has a marked influence upon the eyes. In irri-



tation, as from sand ; inflammation of the eyes, with aching in the ball of the eye ; lachrymation in open cold air ; dimness of sight, as from mist or gauze ; luminous circles or vibrations before the eyes. But its greatest influence is upon the lids, inflaming them and the meibomian glands ; redness and swelling of the lids ; styas, especially if accompanied by menstrual troubles.

Its influence upon the ears is very decided, inflaming the external ear. There is discharge of pus from the ear ; discharge of pus after measles and other exanthematous diseases ; hardness of hearing, as if the ear was filled, with snapping and buzzing and other noises ; lancinating, darting pain ; otalgia.

Its effect upon the nose is to produce pressure and aching at the base ; ulceration of the external wing ; hemorrhage from the nose ; dry coryza ; green, fetid discharge from the nose. In the mucous membrane puls. sets up a catarrhal process.

Pulsatilla plays an important part in disorders of the alimentary canal and in derangements of the digestive functions.

Tongue is covered with white, tenacious mucus, with burnt feeling. Swelling in back of throat ; feeling as if too narrow in swallowing. Taste foul or fetid, sour, bitter, or salt. Frequent distressing attacks of nausea, with little vomiting. Inability to digest fats or other rich foods. In chronic indigestion it is curative where there is heartburn rather than water brash. Eructations after meals tasting of the ingesta, or bitter bilious taste. Gnawing in the stomach, as if hungry. Aching, drawing pain in the stomach early in the morning, attended with a frightened feeling—afraid to be left alone for a minute, with desire to eat every few minutes. Gastritis. Obstinate constipation. Painful sensitiveness of the abdominal walls. Frequent urging to stool, as if diarrhea would set in.

Frequent passages of mucus or stools mixed with blood,

and mucus or diarrhea with blood. Diarrhea at night mixed with bile, or thin and watery, or acrid, with pain in the abdomen and burning in the rectum.

For discharges from the urinary tract it is useful in dysuria during pregnancy.

In hysteric affections with profuse watery urine.

In deposits of a jelly-like sediment.

In chronic cystitis with dark urine and slimy or brick-dust deposit.

Catarrh of the bladder in scrofulous subjects, or from rheumatism, and in urethral hemorrhage.

In chronic stricture from scrofulous irritation, or mismanaged or neglected gonorrhea.

Puls. causes whitish, slimy discharges from the urethra, with burning, hence may be useful in chronic gonorrhea.

It causes frequent ineffectual urging to urinate; this often occurs during pregnancy.

The action of *pulsatilla* upon the circulating system deserves special attention.

It affects the heart more or less; causes rush of blood to the chest, with oppression and unpleasant dreams; palpitation with obscuration of sight; stitches in the region of the heart.

It may be of benefit in congestion of the heart when amounting to hypertrophy of right ventricle, whether caused by rheumatism or menstrual suppression. The burning, stinging pain felt in varicose ulcers is often relieved; readily bleeding varicose ulcers are said to have been healed. Its power to produce venous congestion renders it valuable in the treatment of those troublesome varicoses in females caused by frequent pregnancies. It may be used both internally and externally. It is said to have caused inflammation and gangrene in parts to which the bruised root has been applied. It is often of benefit in hemorrhoidal varicoses; often curative in crural phlebitis after parturition, or phlebitis caused by injuries. It is positive, immediate, and

remarkable in its influence in traumatic phlebitis. This was verified in the case of a young girl who was thrown from an omnibus, causing fracture of the humerus at its lower third. I first saw the case four days after the injury. When called the father of the girl stated that a consultation had been held (of old school physicians, good men of their school) that morning, who decided that there was no hope of saving the girl's life.

I visited her at 2 P. M. At this time there was complete death of the arm below the fracture; circulation must have ceased at the time of or soon after the injury. The fever register at this hour was  $102^{\circ}$ . Gave acon. 6th, to be followed by arnica 3d. Was sent for again at half-past four. Found the patient gasping for breath, and manifesting great fear and excitement. There were then two bright red spots as large as the palm of the hand on each side of the chest just below the clavicle. Diagnosis: rapidly extending phlebitis. Prescribed pulsatilla 6th. Called again at nine o'clock, when I found the crisis passed, the patient lying quietly, breathing easily, without pain or excitement. The evening paper statement was that a consultation had declared she could not recover. While her friends were reading this, owing to the benign influence of the 6th potency of our drug, she was quietly sinking into a sweet and restful sleep, and a life was saved by pulsatilla, the arm being amputated the following day.

Pulsatilla affects both the male and female genital organs. It produces lacerating pains in the testicles. Drawing, and drawing tensive pain in the abdomen through the spermatic cord to the testicle. Is of benefit in swelling of the testicle after contusion or bruising; swelling of scrotum; excessive sexual excitement. Of benefit in atrophy of the testicle, in nocturnal emissions, orchitis, retraction and swelling of one testicle while the other remains normal or relaxed.

Pulsatilla may be of benefit in amenorrhœa with nausea,

trembling, chilliness, cold feet—especially in sensitive, leucophlegmatic females. Sickness arising from sudden suppression of early menses. During menses, pain in stomach, discharge thick and black, flowing in gushes “by fits and starts”—sometimes pale and watery. Discharge of thick, white mucus before the menses; menses coming on slowly. Milky leucorrhœa, burning, thin, acrid leucorrhœa, hemicrania, palpitation, spitting of blood, and other results of delayed or suppressed menses.

Dysmenorrhea; pressing, cutting, and contracting pains in the uterine region.

Spasmodic labor pains during parturition; irregular or deficient contractions; the pains very annoying in the back—all in the back; false pains simulating labor pains coming on before labor. A case of this in illustration: Mrs. C., æt. nineteen, primipara. Met the husband coming when on the way to see another patient; would be at his house in an hour. When I arrived found an allopath at the bedside. Being very young thought they would call him to be present while waiting for me, lest a child might be born and they not discover the fact.

He had decided that labor was not coming on, and had given two doses of morphine to quiet the pain, and bowed himself out. Waited half an hour, when, seeing no result from the morphine, gave the sixth of a grain more—as the patient was supposed to be already under its influence. At the end of an hour more, two and a half to three hours after the first morphine was given, with no diminution of the pain, and no crowding down by the pains, no dilatation of the os, pulsatilla 6th, 6 drops in quarter glass of water, two teaspoonfuls were given, and in twenty-minutes my patient was sleeping. After waiting half an hour to see if there was to be any return of pain I left, to return again in sixteen days, when labor was successfully terminated.

As a preparation for labor, especially when malposition is discovered, it is indispensable.

I will describe two cases in verification. Mrs. K., æt. twenty-two, primipara. In her last month of gestation, 10 A. M. found her in an armchair cushioned with pillows; had not been upon the bed for three days and nights, and unable to stand on account of pain; distress constant. The head of the fetus was so tensely pressed up against the lower ribs of the right side that it was impossible to press a finger between them. There was great tenderness of that locality; general tenderness of the abdomen; tenderness and more or less congestion of the liver. Fever 100½. Acon. 3d was given, to be followed in two hours, by nux v. 6th; 4 P. M. pressure much relieved. At 9 P. M. patient in bed; the crowding relieved; 9 A. M. the following morning found patient had slept well. Prescribed puls. 6th, to be taken every two hours; 4 P. M. found the head had descended the width of the hand; puls. 6th continued once in three hours. The head could be distinctly traced, as it dropped down the side from four to five inches each day until the proper position was reached, labor coming on, with the head in natural position, fourteen days later.

The second case, Mrs. B., carrying her fourth child. Saw her in the latter part of the eighth month, a small, spare woman, who in her former labors had given me much anxiety by invariably becoming delirious soon after labor had commenced, and declaring that she could not and would not be delivered. Found her at this time feeble, nervous, abdomen quite tender, and, as usual, altogether discouraged, the motions of the child causing much suffering. The head was found occupying the left iliac fossa; the child, face upward, was lying directly across the abdomen, the motions of the feet pushing out the thin parietes of the abdomen so as to be at times distinctly felt; seemingly a most unpromising position to be relieved by any remedy. Pulsatilla 6th was given once in three hours during the day and chamomilla at night for the great restlessness. After

the fifth day puls. was given as the sole remedy. The position was slowly changed and the distress from the motions relieved, so that when labor came on the head was found presenting and delivery accomplished without the usual mental excitement.

Pulsatilla is of benefit after delivery in deficiency of milk, suppression of the lochia, inflammation of the veins of the uterus. In newborn infants, ophthalmia, chafing of the skin.

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## DISORDERS OF THE CERVIX UTERI A CAUSE OF STERILITY.\*

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BY

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CHICAGO.

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SINCE the appearance of my work on sterility, the rôle of the cervix uteri in the causation of sterility has been largely discussed, and many of the opinions and theories once held have been modified or thrown aside.

I propose in this paper to briefly mention the supposed causes of sterility originating in the cervix, and state the present beliefs concerning their importance.

I. *Flexions of the cervix* were at one time considered potent factors in causing sterility. My experience has convinced me that altogether too much blame was placed on this condition. I have known many women with cervical flexions who readily conceived.

In fact, retroflexion is such a common condition in child-bearing women, that I cannot imagine how that condition ever obtained any prominence among the causes of sterility. Lateral flexions are so rare that we will pass them by. Antelexions certainly cause sterility in many

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\* Read before the Homeopathic Medical Society of the State of Michigan.

cases, but whether it is due to the narrowing of the cervical canal is not always easy to determine.

The *bent* condition of the cervix of itself cannot prevent the passage of spermatozoa, provided the secretion of the canal is healthy. The spermatozoa measures only  $\frac{1}{8000}$  of an inch in diameter, and moves readily in normal cervical mucus.

Now, a cervical canal may be contracted below its normal size  $\frac{1}{8}$  of an inch, and still be pervious to enough healthy mucus to allow free and unobstructed movements of the spermatozoa. But if the cervical mucus is in the least thickened, or if the mucus of the interior lining of the uterus is unhealthy, it may so obstruct a narrow canal as to be a cause of sterility. This condition is often cured by dilating the cervix. But the cure is not so much caused by the enlarging of the canal, as in allowing a free exit of the unhealthy uterine and cervical discharges.

There are only two medicines which appear to me to have any power to remove flexions of the cervix. They are sepia and the preparations of gold.

II. *Cervical leucorrhœa* is one of the commonest causes of sterility. In its natural state the cervical mucus does not *flow* from the cervical canal. It forms a transparent, slightly tenacious plug, which remains all through the month, to be expelled at the menstrual period.

Shortly after the menses cease to flow this plug again forms, and grows more tenacious, until a few days before the next period, when it becomes thinner.

This accounts for the greater susceptibility to conception a few days before or after the menses. Even this tenacious plug does not seem to be such an obstacle to the progress of healthy spermatozoa as we would suppose. It is when the cervical mucus becomes opaque, *soapy*, purulent, acid, or bloody, that sterility occurs, for then the secretion becomes poisonous to the spermatozoa, or so thick that they cannot penetrate through it to the uterine cavity.

Whenever I discover the "soapy" discharge from the cervical canal, I am sure that I have found the cause of the sterility.

Tyler Smith says this kind of discharge is *very* alkaline, and full of oil and pus.

I judge it must be very poisonous to the spermatozoa, for when the living animalcules are mixed with it the microscope shows that they soon lose their vitality. You have all had cases where the leucorrhœa is thin, watery, and very irritating to the mucus surfaces, and even the skin over which it passes.

This generally comes from the endometrium of the uterine cavity, but sometimes from the cervical canal. Such patients are always sterile.

If Aurum, sepia, sabina, or phosphorus does not remove these diseased discharges, you will have to resort to local applications of iodine, carbolic acid, kali bichromium, creoline, or pinus canadensis to change the condition of the cervical follicles.

The slippery-tent, by exerting non-irritating pressure, often effects a cure.

III. *Ulceration, or erosion*, of the cervix may prove a cause of sterility by causing such an unhealthy condition of the cervical and vaginal secretions as to destroy the spermatozoa before they can enter the canal.

But I have known bad erosions and ulcerations to be no bar to conception. Nor is cancer of the cervix an absolute bar.

IV. *Lacerations of the cervix* may be an indirect cause of sterility, because they are often attended by one of the discharges of the cervical canal mentioned above. If they do not, they rather favor conception by enlarging the os uteri.

V. *A too small os* (pin-hole os) is nearly always a cause of sterility; at least such has been my observation.

A very small os retains the normal secretion of the



canal until it becomes abnormal. It is nearly always accompanied by a *conical* cervix.

Now, with a conical cervix and a pin-hole os, we have two conditions which offer a mechanical obstacle to the entrance of the spermatozoa into the uterus. I have often cured sterility by enlarging the os by incising it on each side, touching the cuts with carbolic acid to prevent closure. But even after such incisions the os has a tendency after time to close up.

I have known a pin-hole os to recur several times after incision and dilatation.

This can only be prevented by the use of a cervical stem of wire.

In conclusion, let it be remembered that sterility is generally the result of an unhealthy state of the cervical or vaginal secretions.

Get the cervical mucus healthy in every respect, and conception will occur, because it is not inimical to the life and movement of the spermatozoa.

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## PROLONGED ABDOMINAL IRRIGATION IN OVERCOMING TUMOR ADHESIONS.

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BY

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I HAVE noticed for years in cases of pleurisy coming to me second-hand that under a treatment where counter-irritation had been used—such as mustard, for instance, that adhesions had formed. Such a condition could not well happen if hot fomentation had been applied. In my experience hot applications are softening, if moisture is added, and the element of its power to keep down the tempera-

ture is an additional quality which it possesses, preventing thickening of the pleura as well as adhesive inflammation during pleuritis.

Bearing the above facts in mind when, during a case of ovariectomy, I found the patient had insufficient strength to endure a prolonged operation necessitated by extensive adhesions connecting not only the intestines with firmly soldered bands, but also the peritoneum to the sac over a large area, and as it was death to proceed as well as to close up, I resolved to try a plan by which the thickened membranes might be softened.

Mrs. Emings, aet. fifty-nine, Welsh, married, and has had three children. Abdominal tumor began two years since; has gradually increased in size, but has suffered no pain to speak of.

The patient took ether badly from the beginning, but great care was used. The fluid when drawn off was dark brown, jelly-like. There seemed a multitude of smaller cysts scattered throughout the abdomen. Over twenty quarts of fluid were removed, but the patient nearly collapsed on our hands, so great was the shock. By the aid of hypodermics, stimulating enemas, artificial respiration, and rubbing with alcohol she was restored. Operation, October 22, 1890.

On December 1, 1890, the patient having been irrigated with large quantities of boiled water each day, and thorough drainage having been kept up, as well as thorough nourishment, she was again opened. All adhesions were easily removed connecting the intestines, and the main sac was easily peeled off. The interesting feature of the case was the softened and comparatively healthy appearance of the peritoneum, which was thickened and of a dark hue on first inspection. Although the operation was over in half an hour the patient again collapsed, and in spite of enemas and other restorers, died six hours later.

Now if this patient had lived I should be especially

delighted in presenting you this paper. Others will have cases similar, however, and I am in hopes that where an operation cannot be completed through similar causes, or in cases which are not undertaken owing to the complications referred to in my case, that a similar procedure may be more successful.

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### CASES WITH COMMENTS.

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BY

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**I**N over 1500 cases treated in private practice but two have been met with in which there was a total absence of the vaginal passage.

The first patient had been married but a short time. She was about twenty years of age; had never menstruated or suffered any of the usual symptoms of the menstrual period. She knew nothing of sexual feelings, but was well developed physically and intellectually. The external organs of generation were small. The hirsute covering upon the mons veneris was absent. The mammary development was also rudimentary. In this case I could find no trace of uterus, tubes, or ovaries.

A fold of peritoneum separated the bladder from the rectum as it passed from side to side in the pelvis in the position of the broad ligaments.

Her physician sent her to me to be operated upon. The operation consisted in the formation of a channel by careful dissection between the bladder and rectum. This was kept open by the use of hard rubber plugs introduced each day and worn as long as it was possible to tolerate them.

The other patient had been married two years. The ex-

ternal organs were properly developed and the mons was covered by its usual covering. The mammary glands, nipples, and glands of Montgomery were well formed. In this patient the cleft between the labia was deeper, but there was no trace of a hymen or vaginal passage, or of a uterus. Upon the right side a simple band marked the fold of peritoneum constituting the broad ligaments, but upon the left there was a distinct mass somewhat sensitive to pressure, which was believed to be tubo-ovarian.

In this locality the patient had complained of occasional severe pains, but this occurred with no such regularity as to suggest regular ovulation. The patient claimed to feel an affection for her husband, but experienced no emotion from his embraces. There had apparently been no recognition of the deformity by either party. Advice was sought because of the patient's sterility and amenorrhœa.

As far as general appearances were concerned both patients were unmistakably feminine. It would be interesting to know if the presence of an ovary in the one case with its corresponding tube *determined* the more perfect development of the external organs of generation in that case, or whether the characteristic features of the female sex can be determined in utero without any internal sexual apparatus. In both of these cases it is likely that there was a failure upon the part of the ducts of Müller to develop into the normal reproductive system and that they merely existed in the most rudimentary condition.

An abnormal congenital development of the external organs has been met with in but one case—a girl of seven years, which illustrated the view held by Courty—that besides the independent and distinctive developmental changes effected in the inner and outer blastodermic membranes of the fetus, to form the internal and external organs of generation respectively, there are separate centers for development in these membranes, which, failing to work in harmony with the general growth of the fetus, may lead

to deformity, and that this lack of harmony may be manifest in excessive growth, as well as in the defective development of one of these centers and even a transposition from one part of the parent membrane to another part of the same.

This little patient was a well formed girl, having from a point above the vagina a red and inflamed mass between two and three inches long and about  $1\frac{1}{4}$  inches thick which protruded from between the labia at all times. In the lower extremity of the mass there was an opening which led into a cavity, from which, the mother claimed, fecal matter had been discharged in hard masses. The rectum and its sphincter back of the normal vaginal opening were intact and healthy. Beneath the abnormal mass could be detected an opening which led into the bladder, while above the mass was another opening, through which the nurse claimed urine was also discharged, but the probe failed to enter the bladder or any canal corresponding to the ureter through this passage. The case was watched for a few days, and as no more urine was discharged from the upper opening or fæces from the opening in the protruding mass while under observation, the mass was excised. It was found to be lined with mucous membrane and contained masses of fecal matter covered with inspissated mucus, showing that it was the lower portion of a duplex rectum which had been closed above by an occlusion of its opposite walls. In a short time after the operation she was well and there was no further trace of abnormality.

The earliest possible recognition of all such deformities is, of course, desirable, but it is especially so in young girls who experience all the pains of menstruation at regular intervals without any flow. In these cases there is often a retention of the fluid either from an imperforate hymen, the absence of a vaginal canal, or an atresia of the cervix.

In one case brought to my attention by the late Dr. Powell of Frankford, a little girl thirteen years of age had

become wasted and pale from constant suffering due to a retention of the menstrual flow within the cavity of the uterus, so that the uterine mass was distinctly felt and seen above the pelvic symphysis as large as a pregnant uterus at the seventh month.

The agony the patient suffered at stated intervals was intense. The external organs of generation were all perfect, but there was no trace of either hymen or vaginal passage. By careful dissection an opening was made which led directly to the cervix. This was next dilated and a large quantity of thick, tar-like fluid was allowed to slowly flow away. After the uterus was completely evacuated it was thoroughly washed out by an antiseptic solution. A drainage tube was introduced and stitched to the cervix so as to be retained. Frequent irrigation with antiseptic solutions was advised, and under this treatment satisfactory progress was made for a week, when the tube was removed. This, I think, was a mistake, for septic metroperitonitis developed and death ensued.

At the *post-mortem* examination we found the pelvic viscera matted together by an inflammatory exudate. The uterus had returned to almost the normal size, but an hematoma of the right ovary, with marked degeneration of the stroma of the organ and distention of the fallopian tube, made it evident that these organs were all infiltrated by blood effused into them under heavy pressure. The left tube was also very much distended and the impression gained from the examination was to the effect that an abdominal section followed by the removal of the appendages and thorough irrigation of the peritoneal cavity and drainage, coupled, perhaps, with an hysterectomy, would be the most desirable treatment in these cases of long standing in the future. No amount of drainage through the new made vaginal passage would restore the tubes, and as the organs were all damaged beyond repair, the indications for their removal were quite conclusive.

An extensive experience in the treatment of lacerations of the cervix by trachelorrhaphy according to Emmet's method has strengthened the view that more confidence can be placed in the effects to be obtained from this procedure than from almost anything surgical pertaining to gynecology. Yet the necessity for excluding cases suffering from tubo-ovarian disease or even severe endometritis from the list of operable patients has forced itself upon my attention quite frequently. Cases with marked symptoms of endometritis require thorough curettage followed by washing, drainage, and packing with aseptic gauze before the cervix is repaired.

Well-selected and properly prepared catgut has answered a very satisfactory purpose for cervical repairs when the double operation of trachelorrhaphy and perineorrhaphia is done at the same time. The single operation of trachelorrhaphy, or the single perineorrhaphia, calls for silver wire, except for buried sutures, of course. Even for complete tears the best results can be obtained from silver wire accurately adjusted from the highest point in the vagina to the outlet. I have discarded the catgut sutures tied upon the rectal mucous surface entirely, as they are a source of infection and detrimental to perfect union.

A number of cases might be mentioned in which serious pelvic trouble gradually developed in consequence of a neglect of uterine prolapsus in young women. These patients first suffer from dysmenorrhea and menstrual irregularity, then the cervix becomes anteflexed and endometritis follows. In some cases fallopian disease also develops in consequence of this neglect. As soon as the disease extends from the uterus to the tubes the danger rapidly increases. The latter organs become heavy, the ovaries enlarge and get displaced. This, with the previous displacement of the uterus, often induces irreparable mischief, resulting in chronic invalidism, only relieved by the removal of the uterine appendages. Before the tubes and ovaries

are involved much good is done by straightening the cervix by dilatation, washing and draining the cavity, and, if necessary, an amputation of the cervix or the employment of Wylie's cervical drainage tube.

All through the domain of gynecology the struggle for asepsis and good drainage persists.

Sulp. has accomplished much for neurasthenic patients, with constipation, menstrual derangements, chronic enlargement of the uterus, and endometritis.

Actea race. for such symptoms in acute case where there is less impoverishment of the system and less hardness of the uterus. Actea is the gynecologist's aconite in one sense. It seems to be indicated for mild and strictly localized uterine engorgement. Add peritonitis to the picture and bryonia is required. Add cellulitis and then belladonna is useful. Again convallaria is the gynecologist's arnica. He wants to use it for the sore, bruised feeling across the lower part of the abdomen, not deep-seated in the intestines and high in the umbilical region like nux vomica, but just across the hypogastrium. Regarding that *bête noir* of our profession, the treatment of fallopian salpingitis, much may be written in favor of the employment of surgical means exclusively for its eradication. Yet it is a recognized fact that a fallopian distention as large as a banana may gradually diminish until the tube is of the normal size if favorable conditions and proper treatment are available.

Mrs. N. consulted me several years ago with a tumor the size of a cocoanut in the right side of the pelvis. It developed without fever or serious systematic disturbance and yielded entirely to treatment within a year, and she has been perfectly healthy ever since. It is a recognized fact that such a distention of the tubes from an occlusion of their extremities sometimes occurs, and that the rapid accumulation of fluid within results in the formation of a tumor-like mass, as was apparent in this case. Leopold has



seen retention of fluids cause dilatation of the tubes to the size of a fetal head. Parovarian cysts are also of rapid growth in some cases and may disappear almost as rapidly as they come.

Mrs. C. had anteflexion with dysmenorrhea subsequent to dilatation. Pelvic inflammation ensued, but she recovered from this, to suffer as much as before. Against my warning on account of this pelvic inflammation she went to New York and had the dilatation done over again and nearly lost her life. A tumor developed as large as a fist, which, however, disappeared without suppuration in the course of a few months. Bryonia 30 was the remedy used, and I believe the tumor was due to a rupture of a blood vessel in the broad ligament, forming an intra-ligamentous hematocele.

Mrs. G. miscarried ten years ago and suffered since from pelvic discomfort due to a left latero-version of the uterus with a somewhat movable mass to the right, about the size of an orange, free from the uterus and somewhat sensitive. Although she was convinced that she should have this mass removed by abdominal section I found it was disappearing so satisfactorily that I declined to operate, and she is at the present time perfectly well. Sulp. 30 was the only remedy prescribed for the case, and she was under treatment about six months.

Nothing is more misleading than a prognosis based upon the evidences of fallopian disease obtained by physical exploration. Once we have diagnosed disease, the amount of suffering and systemic disturbance endured is the only index of its severity. It is not the size of the tube or its sensitiveness even which is a guide for operative interference. Serious deterioration of the general health may result from such slight structural changes as are scarcely recognizable by the naked eye after removal. Pozzi has confirmed this view. He says the integrity of the tube

may be only apparent. The microscope often reveals an inflamed condition when the naked eye is unable to perceive any trace of pathological change. As an illustration of this fact I may mention the case of Miss H., who was struck by a heavy wooden swing in the left iliac region when a girl and always suffered severely from pain in that locality, with increased peristalsis and frequent intestinal evacuations, also persistent dysmenorrhea. Rest in bed for several weeks, electricity, dilatation of the cervix, and constant medical supervision for a number of years afforded no relief that was permanent.

Having decided, against the advice of her family, that she would submit to an abdominal section, I operated last May and removed the appendages by section close up to the uterine cornuæ. The left tube and ovary were changed but very little, only appearing to be more friable and darker than normal, the result, no doubt, of a chronic engorgement which persisted for years.

Without an unfavorable symptom the patient recovered and has not menstruated since, and is free from all former pelvic discomfort.

Again, I might illustrate the futility of persistent medical treatment for diseased uterine appendages by Mrs. M.'s case sent to me by Dr. Dietz of Hazleton, Pa.

This estimable lady had suffered from retroversion with salpingitis and prolapsed ovaries for several years. She was sterile, of a nervous, sensitive organism, and very active. Under ether the ovaries were easily replaced and the uterus quite movable; the tubes were not much thicker than normal. After the ether narcosis I decided to try to cure without an operation, as I had thought would be necessary before this examination, but all my efforts were of no avail, as I have learned there was but little improvement in her condition at the expiration of three months, and I am forced to the conclusion that my first decision was the

best and that this patient would have been cured more readily by the surgical operation first proposed.\*

Just when we may expect to get the best results from careful homeopathic treatment in these cases, and when to operate, still remains an unanswered problem. Conservatism should cease, however, where medical treatment fails.

The same remarks apply to the treatment of fibroid tumors. In the specimen I bring before you the tumor was entirely intra-ligamentous, as you will see, but was removed with the entire uterus. There was also an ovarian abscess, as well as a very large pus tube distended to the size of a sausage. These you will see also with the specimen. They were removed separately. The patient has recovered entirely.

Here is another small fibroid which has a small nodule at one extremity which protruded through the cervix in a virgin, and led to copious hemorrhages. The first examination under ether revealed the fact that the mass of the tumor was sessile and imbedded in the lateral wall of the uterus, underneath the mucous membrane. The cervix was thoroughly dilated, and in three days uterine contractions, meeting with less resistance from a tight cervix, had expelled the tumor from its bed, so that it was pedunculated and was readily removed by means of the ecraseur. We may therefore expect favorable changes in the case of sub-mucous fibroids after dilatation of the cervix in some cases. So that this plan may enable us to remove them more readily by ecrasement or avulsion than by the more hazardous method of enucleation.

\* Since commencing to write this paper the patient has submitted to the operation. The ovaries had become firmly attached in their displaced position. The left one had to be dug out of its bed in pieces, and, altogether, the change effected by the lapse of time was detrimental to the patient and rendered the operation much more difficult of successful accomplishment. She had made a good recovery from the operation, however.

## PUERPERAL CONVULSIONS.

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BYROSWELL D. VALENTINE, M. D.,  
SPRINGFIELD, MO.

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[T is not my purpose to go back to the beginning of the Christian era, or the days of Adam and Eve, and tell you what the physicians or others of those days knew or thought or said in reference to convulsions at or near the time of the birth of a child; and then come along down the slow-going centuries to the present day with a pedantic and borrowed show of erudition to astonish and bore you with a tedious and useless description of the affection under consideration. I am sure that from the very earliest times convulsions occurring at or near term have been noted and described and treated. But you, Mr. President and gentlemen, are familiar with the literature, since the beginning, on the subject in hand. You read it up while torturing yourselves in the office of your preceptors; you listened to it while dozing in your comfortable seats in the amphitheater during college days; you read it over again while waiting and starving in your offices for your first cases in the early days of your professional life; and some of you have witnessed and treated it in all its frightful reality at the bedside.

I wish simply and mostly to relate what I know and believe of puerperal convulsions.

The following are the symptoms: Hurriedly summoned to the bedside of a woman in labor, you notice in her a flushed face, dilated pupils, and evident distress, and the attendants anxious and frightened. Then suddenly rapid winking and rolling upward of eyes, cyanosis, twitching of various muscles, sudden opening and shutting of jaws, great dyspnœa, froth mixed with blood issuing from

between the tightly closed teeth, turgidity of all the veins of face, hurried and irregular beating of heart, spasmodic movements of hands and feet and all the limbs, and almost total cessation of breathing. The picture is a terrifying one, and you, too, are alarmed; but you assure the friends who are watching you that the paroxysm will be over in a few minutes and the woman is not dying. After the lapse of a few minutes the frightful symptoms gradually disappear, and the breathing and circulation return to normal, but consciousness does not return.

After an interval equal to the usual time between normal labor pains the scene is re-enacted. The expulsive efforts are sometimes absent, but not always, I have observed, and although the patient is becoming weaker, are having the desired effect of advancing delivery.

What are the causes? Of course writers and physicians differ in opinion, and if I differ from the authors in my opinion so much the worse for the authors, is all I can say. Some claim the cause is albuminuria, a condition in which urea and other injurious matter which should be separated by the kidneys and excreted through the proper organs is retained in the blood, while albumen, which contains the nutriment needed by the body, is separated from the blood and excreted through the urinary apparatus. If this blood poisoning (uræmia) is one of the causes, and it may be, it certainly acts quite differently in Bright's disease, which is precisely a similar condition of affairs. I consider it doubtful. In my opinion the cause must be found in the presence of a fetus, which is or is becoming a foreign body and so an irritating factor in the case. The contents of the womb and the enlarged organ itself press upon the vena cava, the large nerves, and all contiguous parts, and at or near time for parturition are recognized by the brain as an offending body and must be driven out by force. The situation is something like this: The sympathetic nerves telegraph to the brain that there is an enemy present. The brain, through

the motor nerves, at once sends orders to use all the force required to expel the offending body. But owing to some idiosyncrasy of the patient, or the excess of blood pressure, or undue nervous irritation, or uræmia, or other disturbing element, the orders are misunderstood, and all other muscles besides those of abdomen and womb act irregularly and spasmodically, and so the condition under consideration is the result. Of all the causes enumerated above I incline to the view that great blood pressure in the brain is the main one, since the patient has been complaining of headache and the appearance of face and eyes indicate such a condition.

These patients are usually primiparæ, and were so in all my cases.

Prognosis: This should be guarded. If the bad symptoms can be controlled promptly and delivery hastened and completed properly, it is usually favorable. But the case is an extremely serious one and calls for all the nerve and resources of the accoucheur, and too favorable a reply should not be given to the inquiries of husband and family and friends.

Treatment: As homeopathic physicians such remedies as belladonna, cicuta, gelsemium, cuprum, aconite, veratrum viride, and some others occur to us, and are applied according to indications, but if results are not favorable and prompt, and there is no time to wait, then other measures, as inhalation of chloroform, chloral hydrate by enema, bromide of potassium per orem, cold applications to the head, are imperative. In my cases potassium bromide, in five-grain doses and repeated if necessary, was perfectly successful after a failure of all the homeopathic remedies tried. The hastening or induction of delivery, of course, is usually demanded, since the whole trouble is due to the presence of a fetus in the womb. After that is accomplished convulsions soon cease, although unconsciousness remains several days, disappearing gradually, and the cases, according to my experience, go on usually to recovery.

## DIFFICULT DENTITION.\*

BY

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**A**LTHOUGH strictly a physiological process dentition is so frequently attended with morbid complications that it is generally considered as one of the most critical periods of childhood. The rapid growth and development of the various organs and tissues occurring at the age of the eruption of the milk teeth, render the normal harmonious relation of functions peculiarly susceptible to disturbing influences, and where the nervous system has acquired an abnormal irritability dentition may become an exciting cause of disease. In some instances teething occurs apparently without any disturbances at all, and it is not until the tooth is seen protruding from the gum that dentition is known to be going on; in others it is associated with grave local and constitutional symptoms seriously threatening the life of the child.

Ordinarily the milk teeth make their appearance from the sixth month to the second year, but exceptions occur. Leczsinsky relates cases where children had two or four teeth at birth, while there are others on record where no teeth appeared for more than two years. Delayed dentition is, however, generally due to rickets, since the development of the teeth advances step for step with that of the osseous system.

The relation of dentition to the concomitant derangement of functions, which I believe to be only an indirect one, is frequently misunderstood. This is an important error, since the real causes are overlooked and local measures

\* Kentucky Homeopathic Medical Association, 1892.

are resorted to that interfere with the natural eruption of the teeth and in many cases prove decidedly harmful. Where perfect health has been maintained the eruption of the teeth, being a physiological process, cannot be attended with pathological results. Thus in the healthy child the irritation due to the pressure of the advancing tooth on the dental nerve, while producing a hyperæmia of the surrounding gum for the removal of the impeding tissue, is not a sufficient cause of itself to induce any morbid process. But when the nervous system has become deranged from a dyscrasia or some external cause, as exposure to cold, improper feeding, fright, etc., the irritation may become intense and manifest itself by perversion of functions of remote organs as well as of the adjacent tissues. The fact that comparatively few children are perfectly healthy readily explains why teething is so often associated with more or less morbid disturbance. It is not to be inferred, however, that incidental maladies necessarily assume a graver aspect at the time of teething, for cases of pneumonia, meningitis, etc., have been observed when the cutting of teeth has taken place quite easily in the course of the illness. In these cases the causation of the malady is entirely independent of dentition.

It seems probable that without an abnormal irritability of the nervous system dentition is incapable of producing any disturbance of the normal functions or any aggravation of symptoms of intercurrent disease. When this hyperæsthesia exists dentition may or may not arouse into activity a latent dyscrasia or intensify any symptoms of a concomitant affection. In the first instance of abnormal irritability the disorder produced by teething is merely symptomatic and subsides as soon as the tooth is cut: in the second more or less intense and protracted inflammatory changes result. In the purely nervous form we find the increased secretion of saliva independent of any local inflammation; the vomiting, though frequent, is not so



grave as in gastritis; the cough is not accompanied by *rdle*; the diarrhea is slight and shows no symptoms of inflammation. There is always more or less irritation of the gum, manifested by a strong desire on the part of the child to bite or press its gums against anything it can convey into its mouth, attended with restlessness, sometimes twitchings of the muscles of the face and extremities, and less often strabismus.

Where these symptoms are influenced by a strumous, rickety, or syphilitic diathesis, or some incidental ailment, there will be local inflammations and constitutional disturbance with a more or less protracted course. The alimentary tract, where the glandular system is undergoing a rapid change for the digestion and absorption of mixed food and where an intimate sympathy between its different parts exist, is most frequently affected. In the oral cavity there is great swelling and tenderness of the gum, the mouth is hot and inflamed, and it is not infrequent for ulcerations to form, sometimes extending from the summit of the gum to the inside of the cheek. The tongue is generally coated, and sometimes aphthous ulcerations are seen along its borders. To relieve the irritation of the mouth and allay the thirst the child will continually cry for the breast and is very apt to overload its stomach, in this way producing indigestion, vomiting, colicky pains, and diarrhea. Vomiting and diarrhea are very common disorders attending teething. Bonchut found that out of 138 children 112 suffered more or less from diarrhea during the period of primary dentition. Grave nervous symptoms may develop, such as convulsions and paralysis, especially if the digestive organs are also deranged. Cerebral complications are also of frequent occurrence. Bronchitis often attends dentition, and if the secretions from the bronchial mucous membrane are profuse, lobular pneumonia may ensue. This affection is frequently overlooked, since the symptoms of pneumonia are more or less masked by other complications. On the

skin urticaria, prurigo, impetigo, lichen, herpes, and eczema, especially about the mouth and ears, are sometimes observed. Conjunctival blennorrhœa and otitis are recorded, and from the intimate connection between the dental nerve and those of the eyes and ears it is probable that other disturbances of these organs occur.

Since their manifestation depends upon the constitutional condition of the child, no group of symptoms can be considered as specific of dentition, and the most varied associations occur. While the oral symptoms are the most frequent, cases are seen where distant organs suffer while the local disturbance is so slight as to escape detection. A marked tendency to derangement of the digestive and nervous systems, probably due to their relatively more rapid development, is observed independent of dentition in children of this age, and this accounts, to some extent, for the prevalence of digestive and nervous disturbances attending the eruption of teeth.

The treatment of the disorders attending dentition should be directed against the real causes of disease and the natural processes allowed to pursue their normal course. This has always been the aim of homeopathy, but it is a frequent practice with some physicians to resort to more or less harsh and harmful local measures for "teething," changing a physiological process into a pathological one, while the actual disease has been left to run its course. I do not know to what extent the old school physicians' inherited thirst for blood is to account for such a practice, but as the lancet and the leech are gradually being relegated to the chamber of antiquity, so the practice of gum lancing is now steadily going out of vogue. I believe most careful observers to agree with Dr. Torchheimer, who makes the following statements in regard to gum lancing: 1. It is useless (*a*) as far as giving relief to symptoms; (*b*) as far as facilitating or hastening teeth. 2. It is useful only as blood letting, and ought not to be used as such. 3. It is

harmful (*a*) in producing local trouble; (*b*) in producing general disturbance on account of hemorrhage; (*c*) in having established a method which is too general to do specific good, and too specific for universal use. 4. It is to be used only as a surgical procedure to give relief to surgical accidents. Dr. Scudder records two cases in which the hemorrhage following gum lancing proved fatal. Dillnberger condemns even the chewing at solid objects, since "the irritation in the mouth, the pain, and the secretion of the saliva are increased by it." Each ailment should be treated as if independent of dentition, and the only reliable guide to the proper selection of the remedy is, as under other circumstances, the totality of the symptoms. The symptoms of disease being caused by a hyperæsthesia of the nervous tissue and often influenced by a strumous or rickety diathesis, it follows that such remedies as have a direct effect upon the nervous system or combat the above diathesis are most frequently indicated. Thus belladonna, chamomilla, calc. carb., and calc. phos. stand prominently as remedies of "dentition."

Below are found a few indications for the remedies in most frequent use.

*Aconite*.—Constant restlessness. The child cries, whines, and frets all the time. Dry, hot skin and great thirst. Green, watery diarrhea, or constipation.

*Belladonna*.—Starting, jumping during sleep. Convulsions, followed by sound sleep. Face and eyes red, head hot, pupils dilated. Gums swollen and inflamed, with numerous small blood vessels showing on the surface.

*Borax*.—Sometimes the child will start, cry out, and hold on to things as if afraid of falling. Cannot bear a downward motion. Aphthæ in mouth, causing child to cry out when nursing. Soft, light yellow, mucous stools.

*Calc. carb.*.—Much perspiration about the head during sleep. Child peevish and fretful, very light sleeper. Cold, damp feet. Swollen, distended abdomen, with emaciation

and good appetite. Head large, with open fontanel. Delayed dentition.

*Calc. phos.*—Backward in teething and also in closing fontanel. Peevish and fretful children. Cold sweat on face; body cold. Face pale, sallow, yellowish. They cannot hold the head up. Diarrhea, with much wind; greenish, thin stools. Children refuse the mother's breast.

*Chamomilla.*—Great irritability and sensitiveness of the nervous system. Very cross; wants to be carried all the time. One cheek red, the other pale. Diarrhea, with greenish, yellowish, or whitish mucous stools, smelling like bad eggs.

*Cina.*—Paleness of face, particularly around the nose and mouth. Peevishness. Urine whitish like milk. Grinding the teeth.

*Graphites.*—Eruptions of the head and face, with discharge of a sticky, glutinous fluid. Constipation of large, knotty stools, very offensive.

*Hepar sulph.*—The gums are very tender and painful. Aphthæ. Dry herpetic eruptions on the skin. Craves sour things.

*Mercurius.*—Copious salivation; redness of gums, sometimes with ulcerations in mouth. Diarrhea, with greenish, slimy and bloody stools, with much straining. Profuse sweating, especially at night.

*Creosote.*—Very painful dentition. The teeth begin to decay almost as soon as through the gums. Diarrhea, with dark brown, watery, very offensive stools, or constipation.

*Nux vom.*—The child is very irritable and cross. Especially suited to children raised on cow's milk, etc., or whose mothers indulge in highly seasoned food, wines, etc. Aggravation in the morning.

*Silicea.*—Large head with open fontanel. Profuse sour smelling perspiration on head. The protruding gum is blistered and very sensitive. Constipation; the stool recedes after having been partially expelled.

*Sulphur*.—Open fontanel. Eruptions on skin, attended with much itching. Early morning diarrhea, with whitish, greenish, or bloody stools excoriating the anus. Frequent weak, faint spells.

*Veratrum*.—Diarrhea, each stool followed by great prostration and cold sweat on forehead. Vomiting and severe empty retching. Very weak, faint pulse. Violent thirst for cold water.

*Cicuta virosa*.—This drug is indicated when the child suffers from convulsions. The pupils are dilated. The skin may show an eruption like that of measles. The child may at first appear rigid, with fixed, staring eyes, bluish face, and frothing at the mouth.

*Podophyllum*.—Reflex irritation, as convulsions, with variegated slimy stools. In all forms of infantile diarrhea, with colicky pains, the well-known morning stool pouring out like water from a hydrant, preceded by retching and vomiting, with spasmodic contraction of the stomach, making the child scream out, and prolapsus ani. While it does not directly affect the brain, yet it causes reflex cerebral irritation, whether this be from the abdominal symptoms alone or from the teeth. The head may be thrown back or rolled from side to side.

*Zinc. met.*—Failure to develop the teeth. The child has a slow pulse—just the opposite of aconite—seeming to come in long waves. It is drowsy and lies with back of the head pressed deeply into the pillow, with the eyes half closed and squinting, the face pale and rather cool, or alternately red and pale. The child gives forth loud cries, trembles all over, and bores the fingers into the nose, as in *cina*, *arum triph.*, etc. There will be automatic motion of different parts of the body, usually the arms and hands, and particularly restless, fidgety movements of the feet. If the child wants water it grasps the cup and drinks hastily or greedily. In extreme cases the abdomen will be found hot and sunken. In severe cases the brain symptoms of

zinc may also show delirium, and the child appears frightened when awakened. It seems to recognize no one. The child is almost always cross and irritable before the attack; the body hot, with great restlessness, particularly at night.

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## PHIMOSIS.

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BY

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NEW YORK.

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IN presenting the subject of "phimosis" to this society for discussion, permit me to say that while two varieties are generally considered, namely, congenital and acquired, the acquired form is usually found in those who have passed from the age of childhood, and in that way would not properly come before this society. Congenital phimosis I would define as a contracted foreskin. There are other conditions which often call for treatment of a similar nature, such as elongated foreskin and adherent foreskin. These are local conditions. The consequences which result from these conditions are many, and as enumerated by Dr. Sayre would include neuroses dependent upon reflex irritation from stomach, eyes, nose etc., which are often observed. The most common results are choreic movements of the limbs, feeble muscular action, convulsions, malnutrition, dysuria, nocturnal incontinence, hernia, stone in the bladder. Other reflex conditions no doubt will be brought out in the discussion. Stone in the bladder is found in the child in more than half of all the cases reported. The contracted foreskin with irritation causes pain in voiding urine. The boy holds it as long as possible, and when he is obliged to pass it, it causes so much pain that he only partly empties the bladder.

This residual urine being retained so long and so rich in urates soon forms a calculus—same as in old men when it is the enlarged prostate that prevents a complete emptying of the bladder, and stone results. But the elongated and contracted foreskin is only a cause of reflex trouble; the chief cause is the smegma collected behind the corona which is prevented from being carried out on account of an adherent foreskin. As everyone knows who is familiar with the philosophy of orificial surgery, it is through the sympathetic nervous system that notice of retained smegma is conveyed to other parts of the system.

The treatment must depend upon the condition, of course. My idea is that the thing to be desired is a "freely movable foreskin over a healthy gland," and only a few who are circumcised needed to be had they been properly treated to begin with. Nearly all, or at least nine-tenths, of the male children born have adherent foreskins according to my observations, and only a few of these need circumcising; a very little effort will serve to strip the foreskin back, when the smegma can be cleaned out and a little aseptic gauze put in to prevent growing up again; in three days this is to be redressed, and after ten days it is to be retracted and washed with *cool* water every day by the *mother* until the boy is old enough to wash it himself. In some cases a little dilatation can be made to assist in retracting, but if done early very little is needed, and it is my opinion that every boy should be so treated during the first week of his life; then all these reflex symptoms that there has been so much written about will be prevented, and surely our duty is to prevent sickness whenever possible. Should we find an elongated and contracted foreskin, then the operation of circumcision is indicated; but in performing this operation I would suggest that enough of the foreskin be left so that the corona may be covered, and after stitching the margins of the skin and mucous membrane together all around with a fine continuous catgut suture; if we put in

two silk sutures through and across so as to draw the fore skin down a little and allow the patient to urinate between these silk sutures, we will prevent too much retraction and the corona will remain covered.

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## PHIMOSIS.

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BY

N. C. KEMP, M. D.,

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**P**HIMOSIS signifies such a narrowing of the preputial orifice that retraction of the prepuce behind the corona glandis is either impossible or difficult. This condition may be either congenital or acquired. The discussion in this paper, however, relates for the most part to cases of the former class. When acquired it may be either temporary or permanent, and whether congenital or acquired it varies in degree from cases so slight that the larger portion of the glans can be uncovered, to cases so marked as to offer a serious impediment to micturition.

During early childhood the prepuce is naturally excessive as compared with the adult, and the preputial opening is often small. Many boys reach puberty without ever uncovering the glans.

Acquired phimosis is the result of some local disease of venereal or other origin, which diminishes the size of the prepuce or enlarges the glans. As a temporary condition it is a frequent result of œdema and swelling of gonorrhea, and of the induration of true chancre. The swelling may also be sufficient in other affections to cause phimosis, viz., balanitis, herpetic ulcerations, papillomata, or epithelioma.

Even to summarize what has been written upon the sub-



ject of congenital phimosis would fill a volume, but it is now very generally conceded (1) that genital irritation is frequently the cause of various reflex nervous choreic or parietic conditions, and (2) that the removal of these conditions by the various means hereinafter mentioned is frequently curative, and almost always beneficial.

Neuroses dependent upon reflex irritation from the stomach, eye, nose, uterus, etc., are frequent. The genital nerves are confessedly the most sensitive of any in the body, and both the anatomical and physiological explanations of reflected results are simple. The most common of these results are inco-ordinate and choreic movements, paresis, feeble muscular action, convulsions, epilepsy, dysuria, nocturnal incontinence, prolapse of the rectum, and hernia. Symptoms resembling those of stone in the bladder are not uncommon.

The sensory nerve filaments from the cutaneous and mucous surface of the end of the penis interlace with the muscular nerve supply of the walls of the bladder, and irritation of the former may be followed by contraction of the walls of the latter. The reference of pain to the wrong spot because of this interlacing of nerve fibers is well understood, particularly the pain at the end of the penis as a symptom of stone. The contraction of the bladder when the end of the penis is irritated is but the converse of this well-known symptom. The continual straining of a child with a tight phimosis to empty his bladder may cause a hernia, and hydrocele, it would appear, may be brought on in the same way. In young infants many cases of restlessness at night, defective nutrition, and mal-assimilation are greatly benefited by attention to the genital organs, and the puny, irritable boy may often be rendered plump and happy by dilatation or circumcision of a tight foreskin.

One author on this subject says: It is not rare to see patients with a tight phimosis arrive at a neuropathic state

which has great resemblance to hysteria. Very young children may not be prone to the latter disease, but the doctor in the case may be before he succeeds in curing some of these excessively nervous and irritable cases with chamomilla or any other remedy unless he gets at the exciting cause and removes that.

Hydrocele and varicocele nearly always disappear after the operation, and stubborn cases of chafing and excoriations of the buttocks and thighs vanish as if by magic almost, if not of specific origin.

Many claim to cure hernia by circumcision. I believe, however, that usually in such cases reported cured a mistake is made in diagnosis, and that the condition is generally one of the two conditions just mentioned. The cure of hydrocele may be hastened by the internal administration of arsenic 200.

Sayre has called attention to certain cases of paralysis of the lower extremities and other pathological conditions in boys with phimosis, in which the organ is in almost a constant state of priapism. Even when the amount of retained smegma is not large, the uncleanness of the parts will often set up severe vesical irritation and is also conducive to priapism and masturbation.

Another reflex symptom recently noted is epistaxis, and reflex cough is common.

No physician is justified in overlooking this causal element of disease, and in every obscure case a careful investigation of the state of the genital organs should be instituted. It would indeed be good practice to ascertain in every male child the fact that the prepuce and the glans are separable. On the other hand, while these remote results of phimosis must be admitted, it is proper to add a word of caution against considering all the ills of boyhood as due to a slight narrowing of the prepuce. Children have been circumcised by very judicious practitioners with the hope of relief in well marked and unmistakable hip disease, and parents have

been led to hope that feeble children owed their lack of vitality to phimosis, to the neglect of very obvious errors in diet and hygiene. To promise immediate gain in muscular power when feeble action is due to deficient nerve cells is but to lose the confidence of the patient and bring discredit upon the operation. The diagnosis of the actual condition is usually easily made, but upon its degree will depend the question of treatment.

In general terms, if the contraction is great, the adhesions firm, the accumulations of smegma large and hard, and the orifice of the urethra very sensitive, it is quite probable that these conditions bear a causal relation to the reflex symptoms. Even when these conditions are present, however, it must be remembered that they may be but one factor in the case, and other causes should be earnestly sought for. While feeble, nervous, or idiotic children should be given the benefit of the doubt that genital irritation might be an element in the production of their condition, yet the prognosis should be guarded, and central causes should be thoroughly investigated and treated.

In deciding upon the method of relief the surgeon may clearly divide his cases into two classes, *i. e.*, those of adhesion simply, and those of adhesion and contraction. To attain to the normal standard is to secure a prepuce moving freely over a healthy glans.

Whenever possible to "strip" the glans and secure a freely movable prepuce it should be the operation chosen, since of two operations equally efficient the simpler one should be selected. In newborn children this method is nearly always feasible, and in a large proportion of all young children it will be found an easy one. When contraction is slight, single or multiple incisions of the mucous face are preferable to dilatation, although the latter may be practiced if there is great fear of the knife. Finally, in all cases where reflex symptoms arise and where other plans fail to

give the easily sliding prepuce circumcision should be performed.

The relief of simple adherent prepuce in a young infant requires no instrument; all that is necessary after slight rigidity has taken place from manipulation is to draw the foreskin slowly backward until the point of adhesion is reached, then the penis is to be grasped between the thumbs of the operator while the fingers support the sides of the organ, when, by gentle backward rubbing or traction upon the margin of the foreskin, you may in nearly every case strip it from the glans. The separation should be carried back until the sulcus behind the corona is fully exposed, when all smegma should be thoroughly wiped, or scraped away, and a small ring of borated cotton dipped in cosmoline is made to encircle loosely the neck. The same procedure is applicable to a majority of cases of adhesion in older children, save that a probe or a grooved director is sometimes necessary to break up the union when it has become more decided.

Only in older inflammatory cases will a dissection become necessary. The dressings should be at hand, since if the prepuce is allowed to remain long behind the corona paraphimosis may result and great difficulty be experienced in reduction. The retractions of the foreskin should, with the dressings, be continued several days or weeks.

After the surgeon has practiced this method a few times its simplicity and efficiency will so recommend itself to him that he will circumcise only about half as many cases as formally. Cases which at first seem intractable soon yield and the glans is exposed. Dilatation by means of any ordinary forceps or by means of special instruments devised for the purpose is a valuable preliminary in the more difficult grade of cases under the foregoing line of treatment. When the foreskin refuses to glide backward after adhesions are separated slight incisions may be made to relieve the contraction that exists in the inner surface of

the prepuce. A probe-pointed straight bistoury is carried along a grooved director into the firmly retracted opening, and with the back toward the glans several superficial nicks are made in the mucous surface of the prepuce. The guide for the cutting will be to divide the most rigid parts until the hood slides freely over the glans. Preliminary packing of the pouch with cotton saturated with cocaine solution will often obviate the necessity for ether.

Another modification is the dorsal incision of the prepuce. The preliminary steps are the same except that a sharp-pointed bistoury should be used instead of a blunt one, or it may be made with scissors with one blunt point. A probe or a grooved director is first introduced to sever adhesions and prevent the possibility of incising the urethra. The section can then be made by carrying a sharp bistoury along the director, puncturing the firmly retracted skin at the corona, and dividing by bringing the knife forward. The mucous surface is then thoroughly freed, the corners rounded off, and fine catgut stitches applied. The angles should never be left to form disfiguring flaps on each side of the penis. The dorsal incision is applicable to cases of tight foreskin without redundancy.

Circumcision is the partial or complete removal of the prepuce or foreskin. As a religious rite it is a practice of great antiquity; the age at which the operation is done as a religious duty varies in the different countries in which it is practiced. The Hebrews operate on the eighth day, as is also done in Algiers, while the Arabians wait until the thirteenth year, the age of puberty. As practiced for relief of diseased conditions it may be demanded at any age.

The method of performing circumcision will depend upon the amount of redundant skin. The operation has been performed in a variety of ways, and an almost endless variety of forceps and clamps have been devised for hold-

ing the foreskin and to facilitate the introduction of sutures, etc., but all of these are entirely unnecessary.

The prepuce is first retracted so its mucous surface can be seized and drawn well forward by taking up the tightly stretched edge of the foreskin on either side of the glans with ordinary artery forceps or any similar instrument that will lock, when the prepuce may be excised quickly and easily with scissors. The excision should be made two or three times anterior to the corona and parallel to the margin of the rim, *i. e.*, from above downward and forward so as to remove the smaller portion in the region of the frænum. After this excision a portion of the mucous surface will still cover the glans like a cap. This must be slit up so that the sulcus may be fully exposed.

After cleansing with 1-5000 sublimate solution, the skin and mucous surfaces are united at five or six points with catgut or iron-dyed silk sutures. The catgut stitches are preferable, as even so painless an operation as the removal of the threads is a terror to children, if indeed their removal is not rendered impossible without an anæsthetic. The wound is again thoroughly disinfected, and the parts wrapped in gauze wet in 1-10,000 sublimate solution or a weak solution of calendula and water with a few drops of carbolic acid added. About the penis is then fashioned a nest of absorbent cotton and a napkin applied as a retaining bandage. After each urination if the dressings are soiled the parts should be thoroughly disinfected and the dressings applied as before. Union will, as a rule, be speedy and non-suppurative.

Phimosis due to an indurated chancre may be relieved by internal medication; if, however, satisfactory results are not attained under that line of treatment an operation may be demanded.

In girls it is rarely found that any serious operation is necessary. The nymphæ are seldom so firmly adherent either to each other or to the labia majora that they

cannot be separated by the exercise of a small amount of force.

The hood of the clitoris can also be drawn back in the same manner by the fingers of the operator, and a dissection is rarely necessary. Temporary separation of the surfaces by borated cotton and subsequent cleanliness after each urination will be all the dressing that is required, but the physician should examine the case for several weeks lest re-adhesions occur.

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## UTERINE HEMORRHAGE, WITH CLINICAL CASES.

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BY

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I DO not propose to give a long dissertation taken from various text-books on the *theory* of uterine hemorrhage, for all have probably been bored by the lengthy treatises that have been written, and doubtless many of you have also been bored by the return again and again of patients afflicted with this malady. As we cannot consign these latter to oblivion so readily as the former, although many of even these, no doubt, are not long in reaching the same destination, still these cases are constantly claiming our attention, and we must do something for them. Allow me for convenience to classify into two groups: first, those cases connected with pregnancy and parturition, and, second, all other conditions complicated by uterine hemorrhage. Under the first, one of the most frequent we are called upon to treat is hemorrhage, associated with some stage of abortion. If this cannot be prevented by rest and appropriate remedies we must turn our attention toward a safe and speedy method of termination of the inevitable. The one remedy seems

to be the tampon, and T. Gaillard Thomas, M. D., in his little book on abortion, is most explicit as to the manner of its preparation and introduction—packing the upper part of the vagina with iodoform gauze, and followed by pieces of cotton boiled thoroughly in carbolic acid five per cent., and the fluid expressed between the folds of a towel before its introduction.

If the entire product of conception does not come together there seems to be the widest difference of opinion as to the method of treatment. Some eminent in the profession claim that if the secundines are retained the uterus should be drawn down at once and everything removed in the most heroic manner or the direst results will follow. Sometimes lamentable consequences seem to follow this treatment in the way of metritis, peritonitis, etc. Others say Nature is a kind mother and can manage these cases. The placenta has been retained a week, two weeks, yes, and even months, and no harm came from it. One must be on the watch for sudden hemorrhage, fetid discharge, and be ready to remove *débris*, if necessary; and then there may be patients who will suffer from septic poisoning. Both sides appear to have good arguments, both have their adherents, and not either are always successful in saving their patients.

A well-known author, in an essay on "Experience," says: "Between these extremes is the equator of life, of thought, of spirit—a narrow belt. The mid-world is best." Perhaps many of us would prefer to wait a short time for Nature, but if she cannot do her work and asks for help by sending up the temperature ever so little, raises the pulse, or warns us by hemorrhage, then the time for action has arrived. Remove everything from the uterine cavity and no longer delay. I have seen the placental forceps, if necessary, followed by the use of the *sharp* curette many times without ever a mishap, but there seems to be a prejudice against it in this country. If intra-uterine injections are needed



after above operation, or after labor at full term, I have never seen anything which gave better satisfaction than the glass irrigator.

Often after curretting and thoroughly cleansing the uterine cavity hemorrhage sometimes continues. A patient at one of our clinics not long ago was suffering from hemorrhage dating from an abortion. She had been attended by an old school physician, who said he could do nothing more for her after having curetted the uterus twice, and giving her iron, wine, etc. She had flowed four or five weeks, was very anæmic, the uterus was enlarged, and, being a poor woman, with a paralytic husband on whom she had to attend constantly despite her condition, the prospect was not particularly encouraging. Yet she recovered under china 3x in connection with a carefully arranged diet, and bovine. Helonine was administered a few times at the beginning, but china seemed to gradually control the flow and restore the system to its normal condition. Bell. and ipecac are two other remedies that have been very reliable.

There appears to be a growing conviction in the profession that termination of labor, after the viability of the child, should oftener be resorted to in case of *ante-partum* hemorrhage due to malposition of the placenta. Certain it is that the woman has often lost so much of her vitality by these repeated hemorrhages that when labor actually comes on she often succumbs despite the most careful treatment.

In Vienna I noticed the treatment for *post-partum* hemorrhage was usually the following:

If placenta is still retained express by Credé's method ; if unsuccessful and case is urgent introduce hand and remove at once.

Inject carbolized (three per cent.) ice water into uterine cavity.

Hypodermic injection of ergot into buttocks ; repeat in ten minutes if necessary.

Elevate foot of bed and bandage from feet to thighs.

As last resort plug uterus thoroughly with iodoform gauze wet in carbolic acid three per cent., to be left in twelve hours. Cognac or champagne by mouth and enema of egg and milk.

Under our *second* class would naturally fall uterine fibroids, polypoid degeneration, chronic metritis and ovaritis, and malignant growths. That uterine fibroids would often cause but little trouble if it were not for the hemorrhage, is demonstrated by the fact that they are discovered in *post-mortems*, and had not been known to exist during the life of the patient. Most of the energy of the physician goes toward controlling the exhausting hemorrhages, and, if possible, tide the patient over the climacteric. Anything which has succeeded in this direction claims deservedly much attention. Electricity has won a position of the first rank in the treatment of uterine fibroids; not that it has power to remove the tumor, and rarely diminishes it very much in size, but it has wonderful control over the hemorrhages. Many of Apostoli's followers have made greater claims than Apostoli himself in this direction. He says his patients suffering from uterine fibroids are not *pathologically* cured, but many of them are *symptomatically* cured. They suffer no longer from hemorrhages, consequently regain their vigor, and are enabled to go on with their work in life.

About eighteen months ago a very interesting case of uterine fibroid came under my notice, with the following history: A lady, thirty-five years of age, married at thirty-two; has no children. During the past three years menstruation has been unusually profuse, much prolonged, and occurs oftener than every twenty-eight days; during the past year about once in two weeks. It often comes in gushes, and there are frequently signs of the flow between the periods. She is very anæmic, lips and ears white, and her whole appearance bearing witness to this unusual loss of blood. With the exception of lassitude, an increased

desire to urinate, and occasionally some trouble from indigestion, she made no complaint of her condition. A physical examination revealed the uterus low in the pelvis, os looking directly toward the introitus and large enough for the introduction of the tip of the finger. Cervix smooth, indurated, and elongated; a large, *hard* mass in Douglas' *cul-de-sac*. No sensitiveness whatever complained of during examination. I tried to introduce the sound, but after changing its angle several times, and cautiously trying to introduce it, failed, I concluded she had a uterine fibroid, which had displaced the uterus downward and backward, and was the source of the hemorrhages from which she had been suffering. As these hemorrhages seemed to be the objective point, if they could be controlled I thought my patient might be able to enjoy life once more.

Having seen such good results from electrolysis in such cases, I determined on this method of treatment, but as we all know the physician often *proposes*, and the patient *disposes*. She concluded to go to her old home in New Hampshire for a good, long rest, and I must either give up my patient or change my plan of treatment; so I took the latter course, and concluded to test the efficacy of remedies. I started with china 3x trit. 3 t. d. and it seemed to be of slight benefit. I remembered the testimony of one of our number in the State society three or four years ago with regard to the value of iodide of lime in similar cases. He said he had cured twenty-eight cases with this remedy, though it might take six months or a year to do it.

December 9, 1890, she received iodide of lime, ten grains to a pint of water, with directions to take a teaspoonful in a wineglass of water after each meal. Also gave a powder of china 3x at night. I discontinued this for a while, but found she improved more rapidly with it. I told her to drink all the fresh milk possible, eat eggs and beefsteak, and also gave her bovine 3 t. d. She was to rest during menstruation, as much as possible in the recumbent posi-

tion, avoid hard work of every description, long walks, etc. From this time on there was a gradual improvement. The metrorrhagia soon ceased, the menorrhagia gradually lessened, and she began to regain her strength. She continued to have frequent desire to pass urine, sometimes being obliged to rise once or twice during the night, but her general health improved. There would occasionally be a slight flow between menstruation, and some months menorrhagia, but the general trend was toward decided improvement. Thus the case went on from December to April, when she wrote, "Am still gaining; am feeling real well; have gained in flesh since leaving W. Am sleeping well nights, good appetite," etc. Menstruation was regular all through the summer, and my patient felt well. The 1st of September while out driving she was thrown from her carriage and commenced to flow almost immediately afterward, and after a time she seemed to be almost as bad as she was at first, she said. She came again to my office in November, 1891, and I made another examination. Found everything as before, only this time succeeded in passing the sound and found the direction of the uterine canal forward, and a little to the right, suggesting the location of the fibroid to be in the posterior wall of the uterus. I could detect no difference in size. In my record of the case I find, "Continue medicine, iodide of lime and china, but if hemorrhage doesn't cease shall try galvanism." She again began to improve almost immediately, and in January had a natural period again. January 22 she received medicine for the last time. I have since seen her once. She has lost the anæmic look, has gained in flesh, and is bright and cheerful—certainly a very marked change since I first saw her a year and a half ago. I watched this case with a great deal of interest, and took careful note of the progress made, as I was testing what was to me a new remedy. It has done good work thus far, and I shall try it again.

Polypi soon announce their presence by increased flow at the menstrual period or metrorrhagia. I believe all agree that there is nothing but removal to be thought of in the treatment of these growths. When they have lined the uterine cavity and their removal has been effected the local treatment is varied, and sometimes heroic; at least the application of 100 per cent. carbolic acid seems so to many of us. When we have malignant growths as the cause of uterine hemorrhage we stand before an unconquered foe. We all try to ward off the death blow for a time and are glad when we succeed. We should rejoice if the "similia" could be found for such cases, and would use it in the tincture or em. if success but crowned our efforts.

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THREE CASES OF SCARLET FEVER AND  
MEASLES APPEARING SIMULTANEOUSLY  
AS DISTINCT DISEASES.

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BY

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EARLY in May, 1891, I was called to see two children whom, the father said, had been sick with measles for a week, and as they did not "come to" right he concluded to have a physician.

Arriving at the house I found two little girls lying on a shake-down in the back parlor. Both had been taken vomiting in school nine days previous to this visit, and as there had been an epidemic of measles in that locality, and the majority of the neighbors had worried through without medical aid, my patron had thought to follow suit.

The mother told me that both children had been well "broken out" the first few days and also delirious, but

their eyes had not been sensitive to the light, nor had they coughed at all until that day. A glance decided me in the belief that the disease before me was malignant scarlet fever instead of measles, and the history of the cases strengthened my belief, but the metallic cough and inflamed eyes suggested measles. The cervical and parotid glands were squarely swollen, and the tongues, teeth, and gums covered with a dry, black sordes. The younger one lay with head thrown back and mouth open, in a comatose condition. The elder was wide awake enough, being wild, with a large and painful axillary abscess. Her pulse was 140 and temperature 104°. I pronounced the cases scarlet fever, introduced disinfectants, quarantined the scattered family, and went home feeling unhappy. I felt that something extra was developing, and was impatient for the next day to come; but when it came I found scarcely more than aggravations of the symptoms of the previous day. I then ventured to tell the father that I feared measles were on the road, and not to be alarmed if another eruption appeared.

The following day, which was really the twelfth after invasion, verily I found two "speckled beauties": from head to foot they were covered with the rash of true measles. The axillary abscess was discharging, and the cervical glands hard and red. Both throats were purple with inflammation, and diphtheritic plaques yet lingered upon the tonsils. Upon the occasion of this visit the youngest child, aged three years, heretofore unnoticed, began to assume a prominent position over a wash bowl. Her face was of a scarlet hue, and then *her* trouble began to brew; and it grew and it grew, till a perfect case of scarlet fever did ensue. I then made up my mind that, if I had to report to the board of health three cases of scarlet fever and three cases of measles as occurring with these three individuals, in the brief space of two weeks, to save homeopaths and women from ridicule it would be

wise to call counsel, and to do so while the first two patients were showing plainly the sequelæ of scarlet fever and the measly eruption, and while the little one was in the first glow of scarlet fever; so I straightway invited Dr. Gregory, who is our most able old school practitioner, and also the president of the board of health. This gentleman fully agreed with me in the diagnosis of these cases, remarkable only for their variety. The little one in good time rejoiced in a fine crop of measles, and later a paratib abscess, which discharged freely. The second one chose for her sequela otorrhœa, which yielded to treatment, and later nephritis without albuminuria.

I treated these cases with our homeopath remedies entirely, and they all recovered so that in three months there was no trace of what had been, if I except my bill.

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## THE SIGNIFICANCE OF THE CLIMACTERIC.

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BY

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FEW subjects in all the field of gynecology, it seems to me, can vie with those of puberty and the menopause, those two critical periods of woman's life, in either interest or importance. At puberty the maiden, standing perplexed and mystified by the new experiences which are befalling her, looks back wistfully to the merry, romping days of childhood and timidly forward to the new life, not yet to be comprehended, of maturity and of possible wifehood and maternity, with their joys and sorrows and responsibilities. So inspiring is the consideration of this critical period that we find ourselves overwhelmed with literature concerning it, and no gynecologist presumes to

enter upon his treatment of the subject of menstruation without a more or less elaborate treatise upon puberty and its management.

Yet why should there be less of interest attaching to that epoch in the physical history of every woman when, having borne the burden and the toil of thirty years of sexual life with its more or less constant demand upon her best vitality in the cause of child bearing and child rearing, and in the home making for her family, or, in default of this, then in that active service in the outside world which fills the youth and middle life of most single women, she is brought one day to realize that her summer is not quite ended nor her autumn yet quite begun?

It is very evident that so important a change as this one cannot but be frequently attended by various and, perhaps, serious disturbances in the whole economy; and there is rarely a woman who does not secretly dread, often with great foreboding, those stormy days which she feels must come ere she stand peacefully in the late sunshine of her life's Indian summer. Yet I find among twenty works on the diseases of women, taken up at random, only three which touch upon the climacteric, and these only in unsatisfactory articles of from four to ten pages. As to monographs upon the subject, I believe there are but two modern ones in English, exclusive of magazine articles. The field of investigation is open and wide, and I trust the pen of the modern specialist may ere long give us more knowledge of the pathology and management of the menopause, together with some more rational modes of treatment, than the blood lettings, purgings, cuppings, and issues of the older writers.

First a brief consideration of the general anatomical and physiological changes of this period as it occurs normally will be an aid, I think, in the better understanding of its pathological phenomena.

The prime factor in all the varied conditions of the



climacteric period is the retrograde change which occurs at this time in the ovaries. Who shall tell why at a certain time this organ takes on this characteristic change any more than we can tell why in autumn the flowers fade and the leaves fall? Yet following the inscrutable law which governs both there comes a time when the little organs which have been the treasure house of the very germs of life itself begin to undergo retrogressive change, or, as we say, retrograde metamorphosis. This change, at first microscopic, consists of an increase in connective tissue stroma from periphery to center, which encroaches upon the epithelial elements, and the Graafian vesicles themselves have their ovisacs transformed into a fibrous mass. As a result of these microscopic changes, the entire organ very slowly but surely becomes harder, smaller, and more nodular, until in old age it may present only an induration.

Following this the uterus, too, finally becomes smaller, although at first it may seem larger, from the old time habit of periodical congestion, than the organ which is not now relieved by a flux. In the end its walls are thinner, the internal os narrower or obliterated, and the cervix smaller in every dimension. The vagina, too, shares in the general remodeling, becoming free from rugæ, closer, and often conical in the superior segment. The external organs lose their padding of adipose, rendering prolapsus more possible, and the mammary glands become more or less atrophied.

As I have mentioned above, the ovaries are the moving power in all the changes of the climacteric. In what way? It is through the channel of their nerve connection with near and remote parts. They are richly supplied with both ganglionic and cerebro-spinal nerves, so that whether we consider these systems independent of each other or not matters little in this connection. Here, in these little organs, has been stored, for thirty years or thereabout, that vital fluid, compared by the English Tilt to electricity, which

has been manifesting itself continually in ovulation, and always ready to give itself to the function of reproduction. Now all is changing. There is no further need of this conservation of life force in the ovarian reservoir, and now, therefore, there occur those compensating phenomena which, unless excessive, are but the means to an end, viz., the remodeling of the whole economy, to the end that, these changed conditions having been finally established, the approaching evening of life may bring with it an afterglow of rich health.

By compensating phenomena I mean, for instance, the increased perspiration which is so common, the unusual amount of urinary deposits, principally phosphates, and the abundant mucous flows, which are not always harmful. Both these and the hot flushes and the chills, together with various unusual sensations often referable to the pit of the stomach, are results of the disturbance in the vasomotor system, which so largely governs local blood supply, and of the influence of the changing action of the ganglionic system through its center in the solar plexus.

One can see at once that so radical a change in an entire set of organs entails a vital upheaval in the whole conditions of life ; and while I believe a certain amount of disturbance in many women to be perfectly normal, this very easily, and alas, too often, glides over the shadowy bound between health and disease and shows us conditions with which it is far from an easy task to cope.

We have thus far been considering the influence of a normal climacteric upon a healthy organism, but too many women come to this critical period already the victims of chronic disease or bearing in their bodies the hereditary seeds of death ; and again, women who are apparently healthy at the outset, through imprudence or lack of proper assistance or the development of some unsuspected complication, drift through this time and out of it confirmed invalids.

In bygone days cessation of the menses has been consid-

ered synonymous with the climacteric period, and it was believed that the suppression of the monthly flow was responsible for all the disturbances and diseases of the period. Hence it followed that when Nature, having uttered her mandate that the reproductive function was from that time on to be held in abeyance, and finally abolished, and had gone to work to render the ovaries incapable of ovulation, and the uterus of periodically shedding blood, the doctors said to Nature: We understand this thing better than you do. Leave its management to us. Give us—*not* Shylock's pound of flesh, but our monthly six ounces of good, rich blood. If the uterus will not supply it we must have it from some other source. We will open a vein in the arm. And then, when the patient grows too weak to survive our periodical blood lettings, lest those frightful humors which have always been cast off by the menstrual flow be retained and produce nobody knows what dire disaster, we would fain make an issue somewhere and so correct Nature's processes.

But Nature rebels at this treatment, if the doctors who so insult her wisdom would but understand her, and so she has rebelled all through the centuries till now, for the treatment prescribed by certain modern allopathic specialists differs only in detail from the barbarous practices of the last century. For proof of which statement compare the monographs of Tilt, the English specialist, and of Dr. John Fothergill in 1760 or thereabout. If it is suppression which is the cause of so much trouble through plethora, as these assert, we may well ask why it is that we find often the worst symptoms in those who are supposedly anæmic through copious hemorrhages.

I believe that the thing to be considered is nervous disturbance rather than plethora in the study of many of the minor ills of this period, and perhaps in some of the greater ones as well. The nervous energy which, all through the sexual life, has been devoted to the function

of ovulation, if not of gestation and lactation, is now diverted from its habitual channels and must be otherwise expended. What wonder that, as a result of the introduction of this element of unsettled and wandering vital fluid into the physiological economy, there appear phenomena at once depressing and alarming, if not permanent perversion of local nutrition and consequent actual disease?

Among the lesser symptoms, and often premonitory of cessation itself, come the long train of nervous symptoms, with the flushings and sweatings which have been formerly ascribed to plethora. The nervous symptoms may be of either ganglionic or of cerebro-spinal origin, and vary from slight local hyperæsthesia or nervous irritability to epilepsy or almost any form of insanity. In some cases a woman's whole nature seems to change at this time. The woman who has been gentle in manner and kind to her family and friends may become extremely irritable or bitter toward those nearest and dearest to her, while it more rarely happens that a woman who has been all her lifetime cold and indifferent becomes at this time loving and lovable—like a late-blossoming flower. In like manner the truthful woman becomes deceitful and the retiring woman bold, or the cheerful disposition melancholy, and so on indefinitely. The headache and the pseudo-narcotism, which Tilt describes as a state which resembles intoxication, with accompanying drowsiness, inattention, indifference, and stupidity, also comes in the nervous class.

With regard to climacteric insanity it is well that we can give generally a favorable prognosis, although occurring, as it may, in the form of delirium, mania, or hypochondriasis, kleptomania, dipsomania, and the like; but it is often several years before the mind is fully re-established on its old basis.

Far less serious than any of the above forms of insanity are the uncontrollable impulses which possess some women at this time, and which, I suppose, would have been attributed in the old days to the control of evil spirits. To be

sure, these sometimes extend to even a desire to commit murder or to destroy valuables; but, as a rule, they are limited to comparatively trivial matters. I have a recent case in point: Miss C. G., aged thirty-seven (although she says she always tells the young people she is twenty-five or twenty-six), is in ordinary circumstances. Has had antero-lateral version since fourteen, which was never treated. Always suffered more or less pain, and has been unable to work. Menses began at eleven and have recurred every three weeks, but regularly. Applied to me because she had been told that her womb was attached to something and that she must have an operation to relieve her, and she did not wish to enter a hospital until she had consulted someone else. She has had hot flushes for a year and menstruation very copious and irregular for six months. Is very nervous, melancholy, and lachrymose. She told me that a few days ago she had been washing a lamp-shade and that, when wiping it, she had suddenly thrown it to the floor, breaking it, and then had picked up the lamp itself and had thrown it violently to the ground. Said she was not angry at the time, and that when she had finished she sat down and cried, saying to herself, "What made me do it? What made me do it?" She has frequently done things of this sort, and on this account has feared insanity. Upon examination found chronic displacement, as stated, but nothing which demanded an operation, and decided that my treatment for this patient must be largely mental. I quote this case because, though not a remarkable one, it is very typical and well defined.

Neuralgic affections are very common and will occur, more or less, in nearly all individuals. They may show in the form of dorsal pains, or abdominal or sciatic, but perhaps are more frequently ovario-uterine. This is but natural when we consider that these are the organs most intimately involved and directly affected, while other locations generally suffer reflexly. Neuralgic pain may often

affect eye, ear, or larynx, producing, in some cases, even temporary deafness or nervous aphonia.

The gastro-intestinal tract is frequently affected and in many ways. Constipation and hemorrhoids are well nigh universal, though sometimes a chronic diarrhea may set in at this time, perhaps accompanied by vomiting. The diarrhea, if not too copious or debilitating, should not be rashly checked, although closely watched, as it may act as a safety valve to relieve pressure on some vital organ. Biliary and dyspeptic disturbances are commonly expected and often appear in greater or less degree.

The skin also partakes of the general derangement, with its flushes, sweats, and sometimes eruptions. The sweats usually are a compensating discharge and, with the flushes, are caused by a withdrawal of the proper vasomotor control of the arteries and sweat glands.

But it is to the reproductive organs that we must look for the most serious disturbances, and there we are too sure of finding them. Derangements of the sexual organs may of course be insignificant, if in some cases distressing, as in the various affections of pudenda and vagina irritability, vaginitis and the like, slight endometritis, cervicitis, leucorrhœa, etc. But in the pelvic region do we find, more especially at this time than at any other, those lifelong bugbears of the sex—abnormal growths, both non-malignant and malignant. These may be polypi, hydatids, and granulations, or they may be uterine fibroids or carcinomas or ovarian tumors. Upon these growths the climacteric exerts a tremendous influence for good or ill. Fibroids are in most cases greatly decreased at this time or may, according to Börner, even become pedunculated, and are sometimes expelled piecemeal; or they may rapidly increase and now, for the first time, cause appreciable disturbance. They do not so often begin to grow at this time, unless, perhaps, in the case of fibroma of the ovary, although they are often discovered now. But cancer both of body and cervix of

the uterus is the deadly foe of women at this period. Now, if ever, the germs which may have been lying dormant and unsuspected rapidly develop, and already existing lesions receive a fresh and powerful impetus at the change of life. Now, too, ovarian energy, restricted in its customary activity, may devote itself to the elaboration of morbid cysts or malignant growths of the ovary, and the same organs which, during woman's sexual life, give manifestations of such vigor as can give rise and support to a series of new existences, may now become the abiding place of disease which shall, in time, destroy even her own life itself.

And this brings me to speak of a symptom which is too often neglected by both patient and physician, viz., copious and irregular flooding. Too often it is considered by the laity a necessary concomitant of the change of life, and often does the physician discover too late that the apparently harmless occurrence was in reality a warning of the existence of malignant disease which, if taken in the beginning, might have been checked in its course or even thwarted of its prey. So that it seems to me wise (and I cannot make this too emphatic) in every case where the flooding is copious, or where it does not tend to recur at regular menstrual periods, or where there is any continuous sanguineous or offensive discharge, to insist upon a thorough examination, for it may happen that by so doing precious time may be saved.

Our consideration of pathological conditions has left me little time to devote to treatment, and indeed only a few general hints could be given at best in a paper like this. It seems to me that perfect hygienic conditions at this period are more important, generally speaking, than any other treatment. There are times when the surgeon's knife is the only hope; times when local treatment of the reproductive organs is imperative; times when the sinking vitality should be stimulated or the nervous system controlled like

a restive steed ; but above and before all, as well as in connection with all else, is the necessity for fresh air, good food, proper hours, healthful dress, and last, but not least, the appropriate mental influence.

Often our task as family physicians will be that of the sentinel on the watch-tower, to anticipate danger and to guard against it, not alarming our patient by too grave a consideration of her ills and yet impressing upon her that the slightest untoward manifestations should be submitted to professional wisdom. Let us bear in mind three leading points as inspirations to rational treatment, viz.: That deep disturbance of nervous force is the foundation cause of all climacteric pathology. That floodings at the menopause are never trivial, but are often highly significant. That mental perversions should be treated psychologically as well as chemically, and that if, drugs be required, homeopathy here as elsewhere is king.

So shall we be guided to such wise management of those who come to us at this transition time that we may efficiently help them through this equinox of their lives to that kind autumn time when, if all goes well, there shall come not only rest to the fretted body and freedom from nature's more severe exactions, but an opportunity for new growth and inspiration to the mind. The vitality which has been hitherto expended in answering the demands of the sexual life can, when the system has adapted itself to the new *régime*, be utilized toward the end of fresh cultivation and intellectual growth. Note the rich *coterie* of women in our land who are devoting their later days to philanthropic projects and to the solution of the moving problems of the day. Perhaps we may be able to gain from them inspiration which shall give hope to some who are discouraged and fearful, as some women are at this time, of loss of power in the world. Oftentimes in these late years nature brings forth hidden treasure of unsuspected talent or gives leisure for the pursuit of some favorite occupation.



So that after the excitement and anxieties of the mature life and the tumult of the transition there shall succeed years not the least desirable, filled with peace and healthful happiness.

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## DIPHTHERIA.

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BY

W. H. HANCHETT, M. D.,  
OMAHA, NEB.

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**D**IPHTHERIA has often been called the dread of childhood, so malignant are its ravages upon the young. In truth, may it not as well be called the foe of mankind? Mention the disease and the fond mother becomes sick at heart; refer to it and the strong father trembles with fear. Perhaps no malady has ever attacked our juvenile population with such fatal results. Pathologists have written much upon this subject, and so diversified are their opinions that we are still not certain of its origin; and as to its cure, the wise look wiser and shake their heads, and look doubtful at the same time.

Egypt was among the first nations to suffer from it as far back as the second century, according to some writers; and in 1600 Holland, Spain, and Portugal had epidemics. Down to the present time the disease has taken on different forms, sporadic, epidemic, and endemic. It is maintained by many others that between thirty and forty years ago California was the first of the United States to have cases of the disease within its borders, and in this mild climate and also in the Middle and Southern States it has been more commonly present. Moisture and heat seem to be congenial to the disease germ, and persons of a scrofulous diathesis are much more subject to it than others. En-

larged tonsils with catarrhal tendencies are most likely to be attacked; hence those suffering from colds and sore throats, with chronic or acute catarrh, are frequently taken with the more malignant forms of diphtheria. It is said by a large number of eminent physicians that the diphtheric membrane, and the adjacent diseased tissue and blood of the patient contain vegetable organisms or bacteria in large numbers, called micrococci, which are the true germs of the disease. However, on this question there is a wide diversity of opinion among our scientific men.

Whether diphtheria is an infectious or a contagious disease—whether it comes from bacteria, germs, or other sources, is, of course, a matter of discussion; but certain we are that it comes to all classes and conditions of life, and, when in a malignant form, proves alarmingly fatal. The disease has been on the gradual increase in this country for the last twenty or thirty years; and while health boards have quarantined it, and doctors have fought for its extermination, yet it stalks abroad, defying medical science. We maintain that diphtheria is at first a local disease.

This is shown by the fact that checking the spread of membrane seems to prevent the grave constitutional symptoms which are coincident with the disease when large surfaces are invaded by the membrane. In cases where the pseudo-membrane extends over large surfaces, and is tenacious, the constitutional symptoms are decidedly worse than when it is circumscribed to a small area. The abraded surfaces of the mucous membrane form a rich field from which the absorbents carry the poison germs to the lymphatic glands, and through the entire circulation. A grave constitutional malady follows at once. The glands become engorged and swollen, often going on to suppuration. During this process there is a terrible destruction of tissue and waste of life force.

If this disease germ comes in contact with an abraded mucous surface, or, perhaps, only a slightly congested one, the disease may be infected or "taken"; while people in perfect health, eating nutritious food and surrounded by favorable sanitary influences, escape unscathed.

In this hasty review of the subject we beg leave to refer to a family which came under our care last year. We only mention the circumstance to show how the disease may possibly be generated. The family consisted of father and mother and five children. All of the five children and the father, a man of unusually fine physique, came down with the disease at or near the same time. One of the cases was very malignant; the others of less severe type. The house in which they lived is large and well ventilated; and the food and sanitary surroundings had been above the average. No diphtheria had been in the immediate neighborhood, and, so far as could be learned, none of the family had been exposed to the disease. In casting about for a cause we found that a Newfoundland dog, a great pet of the children, had received an ugly gash about the neck, given supposedly by a burglar, whereupon the dog had left the house for a time. On his return the wound was in a frightful condition; there seemed to be putrefaction and an exudation of a membranous nature. The dog was dumpish and indolent, with loss of appetite, fever, and swollen glands about the jaws. After a time he grew better and the wound began to heal. Soon after one of the children was taken with a well-marked case of diphtheria, and, after her, the others came down in rapid succession, until all the five were attacked.

Whether the disease germs were conveyed by the animal from some part of the city where the disease had existed, or whether the first case was sporadic, is, of course, an open question. Regarding this case we will only add that all recovered, and except in the most malignant case, the first member of the family attacked, no sequelæ followed. In

this case there was a paralysis of the throat muscles which caused some trouble in speaking and swallowing for a time.

The boundary line between malignant tonsilitis and mild forms of diphtheria, in appearance, is so narrow that even the most skillful must be on the alert to detect the difference. A physician can hardly call every case where a small patch of gray or white appears upon the tonsils diphtheria; and yet from this very mild case of diphtheria may be generated a most malignant one in another member of the household.

While during the present year we have had floods, earthquakes, and cyclones, a kind Providence and, it is to be hoped, our more rigid laws regarding quarantine, has spared us from large epidemics of this dreadful disease.

As to the treatment of diphtheria, all homeopathic physicians will agree that the carefully selected remedy is always necessary. In this brief article it cannot be expected that all remedies used in the treatment of this disease can be mentioned. Only a few of the more common will be noticed, with some of the adjuvants which have been found effective.

1. *Aconite* during the first few hours of the disease is always a good remedy; and generally, if the patient has been seen early, should be given.

2. *Belladonna*.—Offensive breath; little membrane; great heat about the head and throat; throbbing carotids; constantly calling for water, and only taking enough to moisten the lips. Extreme difficulty in swallowing.

3. *Kali bich.*—Extremely ropy saliva; difficult expectoration; glands involved.

4. *Lachesis*.—Gray membrane beginning on left tonsil, extending to right.

5. *Lycopodium*.—Membrane extending from right to left.

6. *Merc. cyan.* and *iod.*, when other symptoms appear of a more malignant type. The throat becomes involved, together with the parotid and submaxillary glands. Breath

very offensive. Yellowish or gray membrane on one or both tonsils. Always worse at night. High fever, with sticky perspiration.

7. *Arsenicum*.—Great prostration of body, but constant moving of hands and arms. Intense thirst, but painful swallowing. Very pale and deathly appearance. This is a grand remedy when the blood seems thoroughly poisoned, and when the vital forces seem to be giving way. At this time it may save your patient when no other remedy will.

Among other prominent remedies are nitric and muriatic acids, arum triphyllum, eupatorium, baptisia, gelsemium where there is paralysis, and digitalis in case of heart failure. A long list could be added of those remedies which are often useful and frequently necessary.

Usually an epidemic remedy seems to be the genius for certain seasons. This year we have found kali bich. to be the chosen one. It is a monument to our law of "similia" and a godsend to our suffering little patients.

The adjuvants are proper local treatment and good nursing. It has been our custom for several years to use a gargle of alcohol and water, half and half, or weaker if the patient cannot endure it so strong; and we have given internally, immediately after gargling, two or three swallows of alcohol and water, mixed eight to ten parts water to one of alcohol. In severe cases this is given once an hour immediately after the gargle. It may be stated here that alcohol does not interfere with the action of proper homeopathic remedy. It acts as a stimulant, an antiseptic, and to a certain extent a food, all of which are very desirable in malignant cases. Alcohol in diphtheria is one of the truest friends in time of need.

Pepsin is valuable, as it will hasten the disintegration of the false membrane speedily and uniformly, without harm to underlying mucous surfaces. It is a well-known fact that pepsin does not act upon living tissue, but does act

immediately on dead tissue. It will prove undoubtedly a valuable agent, and has a future.

Papoid in some respects is more available than pepsin, as it can be used as a spray instead of dusting by use of the blower; also the peroxide of hydrogen can be used as a spray, and has a wonderful effect in disintegrating the pseudo-membrane.

Permanganate of potash has often been used as a gargle, but we prefer the bichromate—first decimal trituration.

Listerine should not be omitted from the list. It is valuable in healing ulcers and denuded surfaces.

Gargles, sprays, and all applications are mainly useful in the first stages of the disease for the reason that we wish to keep, as far as may be possible, the disease localized. However, after large surfaces are affected, and the system is thoroughly poisoned, it is the internal remedy upon which we must depend; and we must all admit that whether we accept the theory of the disease being at first local or that it is from the start constitutional, the less surface covered by the membrane the better for both patient and doctor.

In all manipulations extreme gentleness must be used, especially with children. Nose-bleed and hemorrhage from denuded surfaces may be easily provoked, both of which should be cautiously avoided.

Good nursing is of paramount importance. See that your best nurses have your diphtheria cases in charge. Children should not be allowed the freedom of rising when they wish during convalescence. Someone must be with the patient who knows enough to detect heart failure, which comes, as we all know, when the patient is considered out of danger. A skillful nurse is an absolute necessity, for ignorance, no matter how well intentioned, has no prerogative for blundering with a severe case of diphtheria.

The diet is also important. All the way through care should be taken not to overcrowd the stomach, yet urging

all the food that can be assimilated. Hot milk is the mainstay ; beef extract, grape juice, and many other foods come in well, their use, of course, being governed by the age of the patient.

Disinfectants should be persistently used, by spray and fumigation. Bichloride of mercury, bromo chloralum, carbolic acid, and sulphur are among the best. All cloths and handkerchiefs used about the patient should be burned at once.

The patient should be completely isolated. While diphtheria is not highly contagious, as are measles, smallpox, etc., yet it is so highly infectious that we class it among "contagious diseases."

As to the use of prophylactics there is a wide diversity of opinion among medical men. No doubt anything which will promote health and vigor in children is of vast importance. Nutritious food, warm clothing, regular habits, full allowance of sleep are among the important things. Thorough ventilation should be uniformly practiced. Often the epidemic remedy may be given to the exposed child with benefit.

Tracheotomy has proven such a failure that we can only say that it is hardly a factor in saving life in this disease. It is a grave question whether it has not cost more lives than it has saved. Intubation is more successful, and has proven a benign factor in the treatment of diphtheritic croup.

During the past year we have had an opportunity to try intubation in a case most favorable to its application. A boy nine years of age, strong and robust, with but little surface of the throat invaded by membrane, but extending down the trachea rapidly, causing difficulty of breathing ; croupy cough, and complete aphonia. So speedily did the trachea fill that a cyanotic condition soon followed. The heart wavered and became irregular, and signs of impending death were present ; evidently no great amount of

blood poisoning had taken place; the patient was literally dying for want of air. As soon as the tube was introduced and oxygen had entered the lungs all of these symptoms disappeared. The blue look left the face, and the child breathed easily and went on to a rapid recovery.

Our brother, Dr. A. P. Hanchett of Council Bluffs, was in attendance with us upon this case; he is most enthusiastic over the operation in this class of cases, and has repeatedly done the operation in his practice. A set of O'Dwyer's tubes should be in the possession of every physician, and ready for immediate use. You will save those cases which you have hitherto lost if you apply the tubes in season.

Let us hope that we may more thoroughly understand this disease, which has been and is the "dread of childhood" by many an anxious mother; and that, under our homeopathic treatment, the success already attained, as shown by statistics, may be still greater in future. Let us hope that our vocation may indeed be hallowed by the snatching out of the jaws of this fell monster the precious lives of children, whose parents would gladly give their own to save.

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## AN ASEPTIC VAGINAL SPECULUM.

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BY

W. U. REYNOLDS, M. D.,

NEW YORK.

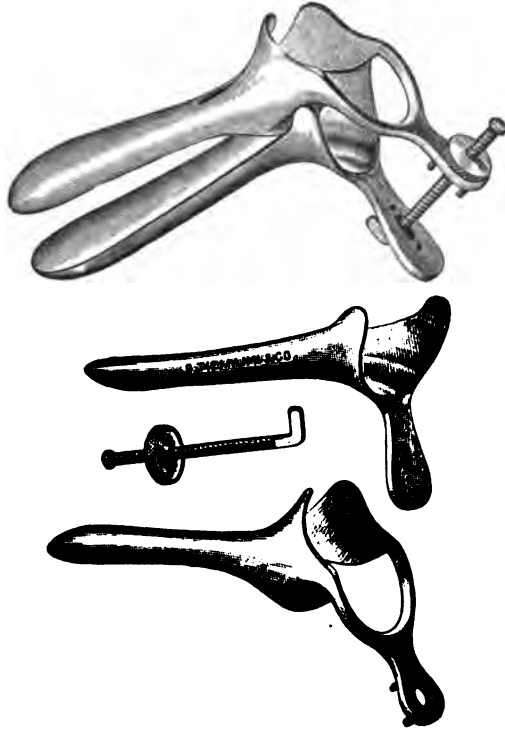
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A MODIFICATION of Brewer's speculum, introducing a new idea in joints, is here presented. As will be seen by the cut, the joint is without pivot or anything to prevent its being readily taken apart and thoroughly cleaned. The instrument consists of only three pieces, viz., the two blades and the screw hook. It can with the greatest



facility be taken apart and put together either as a bivalve or a Sims. When *in situ* the blades cannot separate at the joint, as the harder the pressure the more firmly are they held in place.

To disjoint the upper blade is lifted slightly, turned to one side, and the end of the screw nearest to it brought



upward into the jaws of the lower blade; the hook will then easily come out of the mortise hole in the flange of the lower blade. The screw is next removed from its connection with the upper blade, and the instrument is in three pieces. All the parts of each piece are in full view, and perfectly at the mercy of the cleansing brush and towel. The

parts of the lower blade entering into the formation of the joint are perfectly smooth, affording no harbors for septic matter. The sockets, into which these parts fit loosely, are open and smooth, so as to be cleaned without trouble. They also have smooth surfaces. After cleaning the parts are put together in the reverse order, the screw being first inserted into the round hole in the upper blade, which is then held in the right hand, the thumb on the head of the screw, the hook of the screw pointing away from the head.

The lower blade is held in the left hand, the thumb in the hollow of the blade, and the flange of the blade pointing downward. The point of the hook can now be inserted into the mortise hole in the flange of the lower blade.

The lower blade is then turned downward by the left hand, its jaws placed in the joint sockets, and the instrument is ready for use as a bivalve or to be laid aside. If desired, to prevent rattling, the blades can be fixed in the "open" position by the screw and nut. This joint is more easily taken apart and cleaned than the "French" joint, and can be used on other instruments wherever it is appropriate.

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## ABDOMINAL BINDER: ITS USE AND ABUSE.

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BY

HARVEY DALE, M. D.,

OSHKOSH, WIS.

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To bind, or not to bind, that is the question.

THERE are some traditional customs connected with the practice of medicine which the average physician has come to look upon as gospel. They are a part of his professional scriptures, they are the inspired teachings of his fathers and his grandfathers, and woe unto the ruthless hand that dares tear him and them asunder! One of these

ancient and sacred customs to which many practitioners fondly cling is the use of an abdominal binder after delivery. Their predecessors used it and pronounced it good, therefore they use it. This is routine practice, based not upon reason, but upon precedent only. It stifles independence of thought, it begets mental stagnation, it is an effectual bar to professional progress. Antiquity is not, necessarily, evidence of merit, therefore the past employment of the binder does not prove its necessity, nor even its usefulness. Is it useful, or is it simply ornamental? Is it a *sine qua non*, or is it an abomination? On these points there is certainly room for decided differences of opinion. The subject is a practical one, and one which is worthy of thoughtful discussion. Those who use the binder claim that it is beneficial in three ways:

It prevents flooding.

It preserves symmetry of form.

It secures comfort.

It is granted, of course, that the prevention of flooding can be accomplished in but one way, and that by favoring uterine contraction. If the binder does this, well and good—but does it? Every practitioner who secures the expulsion of the placenta by the method of Credé, or who has resorted to external manipulation in endeavoring to check a *post-partum* hemorrhage, is aware that to produce uterine contractions in this manner requires considerable localized and well-directed pressure. This the binder, as ordinarily applied, does not furnish. Even if it be snugly drawn and carefully pinned, the pressure exerted is evenly distributed throughout the contents of the abdominal cavity, and there is little, if any, more force applied to the uterus than to the liver. Of course this statement will not hold true in those cases in which a compress is applied, under the binder and directly over the uterus. But, granting that the compress remains in its proper place and exerts the direct pressure desired of it, two desirable con-

summations which are seldom realized, there is danger that the after-effects may prove disastrous. Of this more anon.

To preserve the symmetry of the mother's form is of course desirable, if not strictly necessary. It is evident that the chief factor tending to destroy this symmetry is a laxity of the abdominal muscles, and *per contra* the indication for treatment is to restore to these muscles their normal tonicity. For many months the abdominal wall has been subjected to a constant and steadily increasing strain. As a result of this its muscular coats have been stretched until they are weak, anæmic, flabby: weak, because to stretch a muscle elongates its fibers and has an effect precisely opposite to that of exercising or contracting it; anæmic, because the increased blood supply to the uterus has a tendency to exsanguinate the tissues in the vicinity, and also because direct pressure from within interferes with the circulation in the abdominal wall; flabby, because weakness and anæmia together have to a large extent destroyed the power of healthy contraction. To overcome all this the abdominal muscles need, in the first place, rest, the prime indication in weakness or exhaustion from any cause. This rest the binder does not assist, but rather prevents, by acting, to a greater or less extent, as an irritant. Secondly, there is demanded a restoration of the equilibrium of the abdominal circulation. To this the bandage, by substituting pressure from without for that removed from within, is again a hindrance. Lastly, muscular tone must be restored by gentle exercise. This is well provided for by the motion of the abdominal muscles in respiration, which, supplemented by voluntary muscular effort, when the patient has become stronger, is all-sufficient. The binder not only hinders this mild exercise, it positively prevents it. A careful consideration of all these facts appears to lead to but one conclusion, and that that bandaging the ab

domen does not tend to preserve symmetry, but rather to destroy it.

As to how much comfort is derived from the use of the binder, the physician must depend entirely upon the statements of his patient. Some, perhaps a majority, of those women who have had previous experience will declare that they must be bandaged, that they cannot get along without it; on the other hand others, constituting at least a respectable minority, look upon a binder only as a source of discomfort and annoyance, and often proceed to remove it as soon as the physician is out of sight. One thing is certain, and that is that the bandage, to be comfortable, must be properly made and so fitted to the form as to secure uniform pressure. The common method of using a large towel or other rectangular piece of cloth would be effectual if the abdomen were the shape of a gas pipe, but it is not; it is not by any means a perfect cylinder. A square or rectangular bandage will usually be found, on the physician's second visit, wrinkled to half its width and snugly tucked up under the breasts. Naturally this lessens both its efficiency and its comfort, not to mention the engendering of doubt in the patient's mind as to her medical attendant's professional capability.

So much for the binder's benefits—now what are its disadvantages, if any? When a compress is applied over the uterus, continual pressure is exerted upon that organ, and pressure that tends to force it directly backward. The effect of such a procedure can be readily seen upon remembering the anatomical relations of the pelvic viscera. The normal, unimpregnated uterus inclines forward to a considerable extent, its axis forming an obtuse angle with the axis of the vagina. After parturition it is the natural tendency of the uterus to return to this position, but pressure from without will effectually prevent it. The compress, by forcing the uterus backward, tends to make the uterine axis in the same direction as that of the vagina. To do this at

a time when the womb is comparatively large and heavy, and therefore exerting an unusual strain upon its supports, can have but one tendency, and that to weaken those supports and favor prolapsus.

Unquestionably the binder disturbs, to a greater or less extent, the equilibrium of the pelvic circulation. In this connection an interesting question arises: does the binder tend to favor, or to prevent, uterine subinvolution? It would appear that it favors diminution in the size of the uterus, because it causes contraction. But the process of involution is not one of muscular contraction; it is one of degeneration and absorption. After parturition nine-tenths of the uterine substance is superfluous. This useless material must be taken away, and it is taken away, in normal cases, with astonishing rapidity. Now it is well established that moderate hyperæmia favors absorption. In this particular instance the facts appear paradoxical, for an acute congestion is preventive of a subsequent chronic one. As Skene says, in referring to the depletion formerly practiced in cases of subinvolution, "a certain degree of hyperæmia is necessary to the process of involution, and anæmia will arrest the process." That the binder and compress tend to cause uterine anæmia directly as the amount of pressure employed is self-evident, therefore the possibility that involution may be thus hindered seems unavoidable.

A third objection to the binder, and one that is not without its weight, is based not upon specific, but upon general considerations. Labor is a natural a physiological process. It is natural for the uterus to enlarge, natural for it to contract after the delivery of its contents, natural for it to resume its accustomed size, and unaided. It is natural for the abdominal muscles to be stretched and weakened, natural for them to resume their accustomed tone, and unassisted. Are we justified in attempting to improve upon these processes, in offering supposed assistance, which may

in reality prove a hindrance? True, these processes sometimes go wrong, and it is the physician's manifest duty to attend to accidents. But is it not, on the whole, better practice to guard with watchful eye the processes of nature than to attempt wholesale interference? better, in a word, to be conservative than to be meddling?

In conclusion, a resumé of the various points the writer has endeavored to bring out in this article may prove serviceable.

1. The binder does not favor, to any great extent, uterine contraction and its resultant prevention of flooding, unless a compress is used; but a compress tends to cause prolapsus uteri, and may help, possibly, to produce subinvolution.

2. Loss of the mother's figure is rather favored than prevented by the binder.

3. Comfort may be secured to some extent, but only under certain important conditions.

From this it is obvious that, in deciding whether to use or not to use the binder, mere temporary comfort is weighed in the balance as against loss of figure, prolapsus, possible subinvolution. This is practically the whole situation in a nutshell.

To bind or not to bind, that is the question. Every physician must be his own arbiter. His patients cannot well do otherwise than abide by his decisions. "Who shall decide, when doctors disagree?"

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## ADVICE FROM A VETERAN.

*To the Editor of the HOMEOPATHIC JOURNAL OF OBSTETRICS.*

DEAR DOCTOR WINTERBURN:

I have read the September number of your journal with great interest, and for the most part with real satisfaction. Especially was this true with regard to the article entitled "The Better Way." Some of the doctrines and advice contained in other of

the papers, however, appear to admit of just criticism, and so I will try to say my say in the matter.

Perhaps it may turn out a song,  
Perhaps turn out a sermon.

That the hygienic care of an obstetric patient and her surroundings is a matter of great importance and worthy of our closest attention, and that it is often sadly neglected, are propositions which almost go without saying, but

In each extreme there is a vice,  
Over dirty, over nice.

To follow out the instructions as they are laid down in some of those papers would require an armamentarium and a supply of chemicals which would in many situations be more than any man could be expected to carry with him, and which would hardly be intelligently made use of by such attendants as would be found to care for the patient. I agree with you fully as to the benefit and desirability of the most scrupulous cleanliness—that is, strict asepsis; but I remember that I have often attended women in confinement where even a clean chemise to put on the woman was more than the house could afford, and where the doctor was obliged to give the child what washing he could and, after wrapping it in any old garment he could find, leave it to await the arrival of some benevolent neighbor to complete its toilet, and the mother to such care as her neighbors, as poor as herself, could give her. These very poor and destitute patients, you will remember, are not the ones who give us the most anxiety by any means. They seldom have any difficulty in their convalescence, but come up promptly and are soon off our hands. Now in all this I would not like to be understood as advocating filth or slovenliness, but when I look back over forty years of active obstetric practice, before antiseptics were ever talked about, and find that in all those years I can recall but two fatal cases of puerperal fever, I feel like saying to the younger members of our profession that they need not conclude that they must lose their patient although they have not the facilities for washing their



hands in hot soapsuds and then bathing them in a solution of mercuric chloride, followed with a solution of permanganate of potash, and then by a powerful acid to take the stain off. All that sort of thing is very well for those whose patrons are found on Murray Hill or West End Avenue. In such cases the physicians do right to practice all these modern improvements; it is expected of them, and their patients are abundantly able to pay for all their time and trouble, and the physician's skill and efficiency are often measured by the amount of fuss that is made.

There was, however, in these same papers another matter which attracted my attention still more strongly than that referred to above: that was the directions for the care of the patient during labor, and especially in regard to digital examinations. The report says that such examinations are made too frequently. That is no doubt true; I might almost plead guilty to that charge myself. But another one says there should be but one such examination made, and still another that the examination should be deferred till the labor is half accomplished. Will you please tell me when a labor is half over? Labor is by most authors divided into three stages: first, from the beginning of parturient pains till the os is fully dilated; second, from the full dilatation of the os till the child is born; third, from the birth of the child to the delivery of the placenta. Now I ask what particular point in this process we are to consider the "halfway" point? and having ascertained the exact point, by what symptoms may we know that the head has reached the required amount of advancement? The lapse of time will not answer, for we know that some cases will progress more in two or three hours than others will in ten. The discharge of the amniotic fluid is a wholly fallacious guide. In many cases a gush of water is the first intimation the woman has that her labor is about to commence, while in others the membranes remain intact until torn by the doctor's finger, after the cervix has nearly reached the perineum, or the head may be expelled covered by the still untorn membranes. The character of the pains will not tell us, for those peculiar bearing down, forcing pains do not come on till nearly the end of the second stage. But suppose we could tell the true middle of the labor, and some

young doctor, not so well posted as these gentlemen are, having waited till he was confident that the desired middle point had been reached, proceeds to make his investigation, and now finds a malpresentation—suppose he finds the head to be O. P. and well forced into the hollow of the sacrum, he will find it impossible to change the presentation, and must abide his time for nature's efforts, or deliver with the long forceps and almost certainly lacerate the perineum and very likely have a dead child. Now suppose the doctor had used a little common sense and kept himself informed as to the progress which was being made, then, when the membranes broke, before the uterus was closely contracted around the child, a little skill and effort would have changed a very difficult into a perfectly natural labor and one promising speedy relief. Again, suppose the examination reveals a cross birth, with the shoulder or the arm presenting, and the uterus contracted around the child—now the introduction of the hand to reach the feet, which is the proper course to pursue, will be found to be a very difficult operation, whereas if the position had been known and attended to immediately after the rupture of the membranes, the introduction of the hand and bringing down of the feet would have been much less difficult and attended with much less danger to both mother and child.

Many other examples might be given to illustrate the necessity of being fully posted in regard to the condition and prospects of the woman who is looking to us for rescue from suffering and possible death, but these are sufficient for our purpose.

When we studied midwifery we were told that when we were called to a parturient woman our first duty was to ascertain what her condition was; first, whether she was pregnant. Twice in my life I have been called to attend women who supposed they were suffering labor pains, when an examination showed they were not pregnant. Also as soon as possible to know the exact presentation and be prepared to render assistance of the right kind and just when it was required. Such were our ancient instructions, but teaching, like everything else, changes. Are you sure that the change is for the better?

ROBERT McMURRAY.

PROPOSED MONUMENT IN HONOR OF  
SAMUEL HAHNEMANN.

AT the recent meeting of the American Institute of Homeopathy held in Washington City it was

Resolved, That a national monument be erected to the memory of Samuel Hahnemann in the city of Washington, and that a committee be appointed to solicit subscriptions and take charge of the project.

The following committee was appointed in accordance with the resolution: J. H. McClelland, M. D., chairman, Fifth and Wilkins Avenues, Pittsburg, Pa.; I. T. Talbot, M. D., 66 Marlborough Street, Boston, Mass.; J. P. Dake, M. D., 218 North Vine Street, Nashville, Tenn.; J. S. Mitchell, M. D., 5954 Prairie Avenue, Chicago, Ill.; Tullio S. Verdi, M. D., 815 Fourteenth Street, Washington, D. C.; J. B. G. Custis, M. D., 110 East Capitol Street, Washington, D. C.; Henry M. Smith, M. D., secretary and treasurer, Spuyten Duyvil, New York City.

The committee enters upon its duties and desires to lay before the profession its plans as far as matured for the purpose of engaging its hearty co-operation.

The Columbian year is counted a most auspicious time to enter upon the project of raising a monument to this veritable Columbus of medical discovery, and the committee feels confident that the profession and the people will join with enthusiasm in doing honor to the man whose learning and genius brought about the greatest reformation in the history of medical science, by the discovery of a rational theory of drug action.

The plans look to the erection of a heroic statue in bronze upon a granite pedestal—a grand work of art which will make necessary a fund of from \$50,000 to \$75,000.

For such a monument there will be no difficulty in securing a most eligible site on one of the public squares at the nation's capital.

Upon the announcement of the scheme in Washington

over \$1000 was subscribed at once, and at a meeting of the International Hahnemannian Association additional subscriptions to nearly as large an amount were received, and a committee appointed composed of Drs. Custis of Washington, C. C. Howard, 64 West Fifty-first Street, New York, and R. L. Thurston, 136 Boylston Street, Boston.

This is only a beginning, but gives evidence of the intense interest displayed in the movement.

It is confidently expected that every homeopathic physician will feel proud to have a share in this work, and will also find subscribers among the laity, people who have profited much from the discoveries and labors of the illustrious Hahnemann.

It is urgently suggested that State and local societies appoint energetic committees to canvass the membership for subscriptions, and that action be taken at once; also that names and amounts subscribed be forwarded immediately to the treasurer or any member of the committee, in order that a full list may be published. Checks should be drawn to the order of the "Hahnemann Statue Committee."

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#### A CORRECTION.

IN the July (1892) number of this JOURNAL, page 404, line 13 from above, you will find the words: "So Hahnemann prescribed belladonna the 30th." The statement of potency here is an error, as the original says that a  $\frac{1}{155,000}$  part of a grain of belladonna extract was used, which would be a little less than the fifth decimal dilution. On a following page, however, Hahnemann says that he considers a twenty-four millionth part of a grain the proper dose for prophylaxis, which would correspond to a dilution between the seventh and eighth decimal. It is certainly of great interest to read Hahnemann's article in which these statements occur in his lesser writings, entitled, "The Cure and Prevention of Scarlet Fever."

DR. MARTIN DESCHERE.

## MISCELLANEOUS.

—In leucorrhœa the character of the discharge is often of less importance than the subjective symptoms.

—Natrium muriaticum is useful for the weakness of the abdominal muscles from too much bandaging after labor.

—Kali carbonicum is useful when during labor the pains are sharp and cutting, but inefficient, in anæmic women.

—The meddlesome application of obstetrical fingers in hurrying dilatation of a slow cervix, or in forcibly pushing the neck over the occiput during a pain, is a most frequent cause of cervical laceration.—*Prof. McDonald.*

—In cholera infantum good results are frequently obtained by withholding milk entirely and administering a few drops of bovine in water which has been thoroughly boiled, until the stomach can with safety digest its customary diet.

—Premature labor may be induced by the method of Schrader, of Hamburg. This is the alternate use of the hot and cold douche. The irrigation begins with the hot water (112° Fahr.), about half a pint, followed in a few minutes by the injection of a pint of quite cold water (50° Fahr.). This is repeated every hour and a half until the uterine contractions are quite decided. This takes usually about fifteen or eighteen hours.

—M. Charnier discusses (*Archives de Médecine*, August, 1891) early curetting as a therapeutic and prophylactic measure in puerperal infection. Considering the uterus after delivery as a wounded surface, the main factor of the treatment is to keep it aseptic. Especially after abortion a neglectful *régime* is apt to be the starting point of a number of more or less serious accidents. Even when the infection is but of a mild type and the ensuing fever moderate in amount and short in duration, as the patient returns to her ordinary life the trouble begins. Indications for immediate operation are repeated shivering, a quick, wiry pulse, and a temperature of 102° Fahr. If abdominal tenderness and fetid lochia are also factors of the case, the operation is all the more imperative. The curetting should be done with great gen-

teness, using a non-cutting instrument, and under aseptic conditions. An anæsthetic is not required. After the operation the uterus is washed out and the cervix packed with iodoform gauze. The objections raised against this treatment is that intra-uterine lavements are generally sufficient ; and, secondly, the supposed gravity of curetting the uterus after delivery. Antiseptic injections may render the *débris* powerless from a bacteriological point of view, but such patients do not thoroughly recover. Besides, the operation of curetting, if carefully done, is never followed by evil consequences.

—The application of medicaments inside the uterus is not as favorably looked upon in the gynecological world as it was some years since. At the October meeting of the Philadelphia County Medical Society, Dr. C. P. Noble made the following remarks bearing on the general subject of such applications : “ My own experience has led me to the conclusion to which the attention of the profession was called by Dr. Emmet, that applications inside of the uterus are very seldom indicated, and that their field of usefulness is extremely restricted. I think that Dr. Emmet and his co-laborers have shown that the majority of cases of discharge from the uterus are not caused by inflammatory trouble inside of the uterus, but by disease outside that organ, and, therefore, it is illogical to make applications to the interior of the uterus in the class of cases under consideration. Treatment of the causative lesions in these cases is much more satisfactory, less painful, and free from certain dangers which attach to applications to the endometrium—including uterine colic and salpingo-peritonitis. I am, however, quite satisfied that there are cases in which it is proper to make applications inside of the uterus, as, for instance, cases of purulent endometritis, due to gonorrhea, for example. In fungous endometritis, where the condition is not sufficiently marked to require the curette, applications to the endometrium are useful and will often effect a cure. In the condition formerly called endometritis, the evidence of which was uterine discharge. I take it that treatment of the endometrium is not indicated and is harmful rather than beneficial.”

—A successful operation by abdominal section for the removal of an extra-uterine sac which communicated with the

bowel is reported, in *Der Frauenarzt*, by Dr. Flothmann. The patient, who was nulliparous, aged thirty-four, noticed cessation of the catamenia in the middle of the year 1882. As the abdomen became swollen, she early in 1883 consulted Dr. Stephan, who diagnosed pregnancy, and her confinement was expected in February, but nothing took place at that date beyond a few pains and bloody discharge from the vagina. After passing through several hands, an exploratory operation was performed in February, 1889, as, although she had been able to do her work as a cook for six years, she ultimately became very weak. A tumor was discovered and supposed to be carcinomatous, so the wound was closed. On September 4, 1889, fetal bones began to pass from the bowel. On September 9 Dr. Flothmann explored the rectum after Simon's method, and found that the perforation of the gut, which lay more than nine inches above the anus, admitted the tips of two fingers; a parietal bone presented. On September 30, 1889, Dr. Flothmann operated. The sac was firmly fixed in the pelvis, so that he could not sew it first to the parietes, and then open it. He detached numerous intestinal adhesions, and packed sponges around the sac, which was then laid open. It contained fæces and part of the fetal skeleton, and proved to be a right tubal sac. One parietal bone was incorporated with the wall of the sac, and had to be pulled away bit by bit. The sac was drawn forward and washed out, and its borders sewn, by numerous very close sutures to the edges of the lower part of the abdominal wound. The sac and lower bowel were thoroughly washed out from the abdominal wound, the injected fluid passing out of the anus. For this purpose the operator introduced the tube of the syringe into the sac, and his assistant, who had passed his hand into the rectum, was able to pull the tube through the fistulous aperture. For three weeks the bowels were opened through the sac and abdominal wound alone. After that period motions passed by the rectum; the edges of the fistula were touched with chloride of zinc and dressed with idioform gauze. By November 25, 1889, the patient was almost well; she had gained twenty pounds since the operation. Dr. Flothmann saw her a year later; she was in excellent health; the fistula had been completely closed for several months.

—A case of labor, followed for months by a daily discharge of over two quarts of watery fluid through the cervical canal, is reported in the *Journal of the American Medical Association*, by Dr. J. H. Bradshaw. The patient, sextapara, was confined December 9, 1890; podalic version was performed on account of face presentation, but not before two ineffectual attempts with the forceps had been made. The child was a male, weighing  $12\frac{1}{2}$  pounds with a large ossified head. It was dead. The woman had been in labor two hours. After the birth of the placenta there was an unusual amount of hemorrhage, and the patient went into a condition bordering upon collapse. The extremities were bandaged and ligated, and whisky was administered with digitalis by hypodermic injection. Two quarts of a hot corrosive sublimate solution 1-3000 were thrown into the uterus, the hand carrying the nozzle of the syringe to the very fundus. There were no new lacerations to be discovered, and the patient made a fair convalescence without much pain and with but little elevation of temperature. Three weeks after delivery the patient was seen because of a flow of water that came from the vagina, wetting the bed and everything upon which she was placed. Fearing the existence of a vesico-vaginal fistula, the patient was carefully examined with a speculum. The vaginal wall was intact, and a watery discharge could be distinctly observed coming through the cervix, which was badly lacerated. A pint of a colored solution was injected into the bladder; but none came through the cervix, the patient after a few minutes passed the entire quantity again *per urethra*. As the patient's life was made miserable by the constant wetting, one of Jay's urine bags was inserted into the vagina to catch the fluid that came so copiously through the cervical canal. During the first twenty-four hours this caught just eighty ounces of a clear, colorless fluid, of no smell, a slight cloudy sediment on standing, sp. gr. 1001, alkaline reaction and slightly albuminous. Microscopically, there were found pus cells, granular detritus, a few large epithelial cells and fibrin. The patient had voided in this time eighteen ounces of urine of a rich amber yellow, sp. gr. 1018, acid in reaction, and with normal appearance under the microscope. An examination of the patient revealed nothing in the pelvis or abdomen out of the



way; she had herself never felt any swelling or abdominal tumor; she had never had a large abdomen.

During December, January, and February the patient passed daily through the cervical canal actually over two quarts of this colorless fluid. Her appetite and general health were fairly good; she gained in weight and flesh; there was never any distention of the abdomen. But the patient was an invalid—she could do no work, and lay on her bed most of the time.

During the examination a probe was passed, apparently through the fundus of the uterus, into the abdominal cavity. It entered easily and without force, almost to a limitless extent (at least its entire length and that of its handle), while its point could be felt close under the abdominal wall above the umbilicus.

For three months she passed about two quarts of this colorless fluid through the uterus. At the end of this time the patient was given half a grain of codeia every three hours, and in two weeks' time the patient removed the Jay bag as she passed but a few drops of fluid per day. The codeia made her very drowsy at first and rather constipated, but not so much so but that an enema would give relief. The codeia was then stopped, whereat the discharge began again, but only to the extent of four to sixteen ounces a day.

Six months after her confinement, the patient provided, she kept still, passed little or no fluid. If she walked about she voided from two ounces to a pint a day. She still takes the codeia, but at intervals of several days, and then only if she has pain or if the discharge of fluid is profuse.

After watching and studying the case for a long time Dr. Bradshaw affirms that this fluid comes from the peritoneal cavity and is generated by the peritoneum.

—Poisoning from a two per cent. solution of carbolic acid is reported by Krukenberg, in the *Zeitschrift für Geburtshülfe und Gynäkologie*. A multipara had aborted, and it was thought advisable to curette and wash out the uterus. The curette brought away about a teaspoonful and a half of necrotic decidua, following which the fluid was injected. After three-quarters of a quart had been used, the receptacle holding the fluid was raised upon the shoulders of a woman of average size. During the injection

the patient's pulse suddenly failed, and it was necessary to interrupt further procedures. An improvement in the pulse was followed by failure of respiration; artificial breathing was performed, and the patient gradually rallied to consciousness, presenting symptoms of oedema of the lungs. A specimen of urine passed two hours after the injection showed evidences of carbolic-acid poisoning and contained oxy-hæmoglobin. Four hours after the patient complained of prostration, and expectorated an abundant mucus from the lungs. Her most striking symptoms were oliguria, complete anorexia, and the persistence of a scanty, brownish, vaginal discharge. The spleen was enlarged. Death followed about ten days after the intra-uterine injection. *Post-mortem* examination revealed acute parenchymatous nephritis with endocarditis. A microscopic examination of the kidneys showed multiple hemorrhages in the connective tissue between the tubules. Krukenberg has reviewed the literature of the subject and concludes that severe intoxication may follow the use of a two or three per cent. carbolic acid solution resulting from absorption of the poison through the respiratory or digestive tract. In puerperal cases poisoning results from entrance of the solution into the veins of the uterus. The symptoms produced by such absorption are due to the effect of carbolic acid upon the blood, and not to reflex action. Hæmoglobinuria is occasionally observed accompanying carbolic-acid poisoning. And yet carbolic acid is claimed to be the safest antiseptic for intra-uterine use.

—The term endometritis needs to be more strictly defined than its usual acceptance, according to Dr. F. D. Schmal. Although the application of this term has been recently greatly limited, owing to the researches of many French gynecologists, Dr. Schmal, in *Archives de Tocol. et de Gynéc.*, insists that the common diffuse hypertrophy of the mucosa of the uterus, hitherto considered to be simply a form of endometritis, is in no sense inflammatory, either in its nature or even in its origin. Hence it must be separated from endometritis, and termed hypertrophy of the endometrium. The several elements of the uterine mucosa play a very different part in this hypertrophy in individual cases, but the varieties which are thus produced are of no clinical import, nor need the pathologist hold them to represent distinct diseases.

Dr. Schmal claims to have discovered a clinical fact of importance to all who dilate the uterine cavity and operate, or scrape, or apply solids or fluids to the endometrium. In fibroids that project into the uterine cavity the endometrium pushed forward by the tumor is atrophied, while, on the uterine wall opposite the tumor, it is hypertrophied. The state of the uterine mucosa in fifteen cases of fibroid is carefully described in Dr. Schmal's paper.

—That the placenta may remain attached to its site, and continue in growth, after an abortion, is a fact recognized by many obstetricians. An instance of this is mentioned in the *South California Practitioner*, being reported by Dr. W. P. Chunn. The patient was twenty-eight years old, and had been married five years. She had had no children at full term, but had had three miscarriages. The first and second miscarriages occurred at about the fourth month of gestation. The last miscarriage occurred about May 10, 1890. She had missed one period and believed herself to be about six weeks pregnant. On the 10th of May she began to have bearing-down pains and hemorrhage, with the expulsion of blood clots, lasting three or four days. Then the pain subsided, the hemorrhage ceased, and I regarded the uterus as empty. On the 12th of June, however, she was again seized with violent pains, and during the night was delivered of a placental mass larger than a man's fist, which I saw the next morning. The patient as well as myself was surprised. The fetus was searched for, but no sign of it found.

—Secretion of blood instead of milk is a very rare condition. Selenium is the only drug, as far as we are aware, that produces it, though phytolacca causes an admixture of blood with the milk. Dr. Habergritz, of Witebsk, Russia, reports, in the *Allgem. Med. Central Zeit.*, a case of the secretion of blood in the breasts. The patient was a young married woman, who, when she had been pregnant with her first child about six months, consulted Dr. Habergritz as to whether the fetus was alive. He noticed some blood stains on her linen in the neighborhood of the breasts, and on examination found that drops of pure blood could be expressed. The patient said that the bleeding had begun when she was five months pregnant, and she did not know that it was

an unusual occurrence, and therefore had not mentioned it. During the rest of the pregnancy the phenomenon continued and the patient suffered besides from two or three attacks of epistaxis. Two days before labor came on the bleeding ceased, but it reappeared in increased amount the day after. The patient was very anxious to nurse the child, but, as it drew nothing but blood, this had to be discontinued. On the seventh day the color of the secretion began to change, and by the eighth it had all the characteristics of ordinary colostrum. The child was then allowed to take the breast, and nothing further abnormal was observed. It should be mentioned that the woman was perfectly healthy; there were no traces of gout, hemorrhoids, cancer, or of hemorrhagic diathesis. It is possible that this was one of those vicarious conditions for which bryonia is so effective a remedy.

—Public vaccinators are never able to observe any untoward effects from the practice of that rite. Fifteen hundred dollars a year acts like blinders on horses. Dr. Taylor, who for many years was the head of the vaccine corps in New York, told the writer that he had never seen any ill effects from vaccination; but none are so blind as those who will not see. A somewhat unusual case of true epilepsy caused by vaccination is cited in *Archives de Neurologie* by Dr. J. Althaus. The patient was a healthy youth of nineteen. Great stress is laid upon the fact that the family and personal histories of the patient were most excellent. In the commencement of June, 1888, he was revaccinated, having been previously successfully vaccinated when a baby. A week later there occurred a pustular eruption, severe lymphangitis and swelling in the right knee and tibio-tarsal articulation. Emaciation set in, and at the end of the month he had his first attack of epilepsy. These seizures were attended with all the classical symptoms of that disease, and were of very frequent occurrence. In the month of May, 1889, he remained two months in Regent's Park Hospital, at London, where the attacks were first lessened and finally cured by the use of bromide of potassium, arsenic, and hyoscyamine. Althaus has followed the subsequent history of this patient, and states that there has been no return of the attacks.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

## NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

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## ABDOMINAL PREGNANCY.

BY

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ROCHESTER, N. Y.

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MRS. R. M. L., farmer's wife, age thirty, mother of two children, through the kindness of Dr. Norton of Albion presented herself for examination April 15, 1891. With the exception of an acute attack of insanity and prolapsus uteri two or three years before she consulted me, she had enjoyed good health. When conception took place she was quite well, and remained about as she had been with her normal pregnancies until the second month. At this time she was taken very suddenly and violently ill with what was diagnosed as inflammation of the left ovary, and was confined to her bed for one week. There was considerable fever, elevation of the pulse, and the abdomen was distended and very sensitive. A bloody vaginal discharge appeared, but its characteristics were not noted. The menstrual flow again returned the fourth month, but it lasted for a day or two only. Motion was noticed the eighteenth week, and there was severe abdominal pain until

it ceased, about one week before spurious labor began, at the ninth month. Abdominal pregnancy was not suspected, and a physician was called to deliver her child; he remained by the bedside a day or two, and finally gave up the watch, as severe labor pains produced no effect except to expel several clots, which, unfortunately, were not examined. The breasts filled with milk, which had to be drawn at intervals for several days, and she was confined to her bed one week. From this time on she was able to be about and superintend her household duties.

The abdomen diminished but slightly in size, and when she consulted me last April, fifteen months after conception took place, the contour of the abdomen was like that of a patient pregnant at term, yet fluctuation was not well marked. A vaginal examination showed that the pelvis was filled with a hard, immovable tumor, but the outlines of any portion of the child could not be made out distinctly on account of the sensitiveness of the parts; but when an anæsthetic was given the legs of the child were plainly felt and recognized. The uterus was crowded forward and drawn high up, so that the cervix was almost beyond reach of the examiner's fingers. The sound passed into the organ to the depth of  $5\frac{1}{2}$  inches, and the fundus could readily be felt through the abdominal walls above and to the right of the pubes. She entered the Rochester Homeopathic Hospital April 23, and the following afternoon the operation was performed. An incision was begun at a point three inches above the umbilicus and carried down to the fundus three inches above the symphysis pubes. This exposed the sac, and the child could be plainly felt. The patient was turned on her side and as much fluid drawn off as possible. Towels were packed around the relaxed sac, which was strongly drawn through the wound with several pairs of Spencer Wells' pedicle forceps and incised. This exposed a fully developed macerated child, surrounded by putrid, purulent fluid,



**Extra-Uterine Pregnancy of Fifteen Months.**

**Length, 21 ½ inches; Weight, 7 ½ pounds; Operation May 1, 1891. Recovery.**

which was not allowed to escape into the abdomen. The child, which weighed  $7\frac{1}{2}$  pounds; and as much of the large degenerated placenta as possible were removed, and the sac thoroughly washed out with a ten per cent. solution of peroxide of hydrogen. Careful inspection of the external surface of the sac showed that it grew from the posterior segment of the uterus, and was firmly adherent to the abdominal parietes, as well as to the omentum and numerous coils of intestine. The sac could not, by any safe means, be removed.

The abdomen was thoroughly cleansed by irrigation and sponging, and a large glass drainage tube placed down to the bottom of it, at a convenient point by the side of the uterus. The sac was stitched to the abdominal wound by interrupted sutures of silk placed about five-eighths of an inch apart, and great care was taken to adjust the sac closely around the drainage tube, which was placed into the cavity of the abdomen. A double rubber drain was carried down to the bottom of the sac, a depth of ten inches, and iodoform gauze packed around it until the cavity was filled. A heavy dressing of gauze and cotton with protective was placed over the abdominal wound and retained by a flannel binder. There was no perceptible shock, and she vomited but little from the chloroform. With the exception of slight smarting around the wound, she expressed herself as feeling better than she did before the operation.

The first day the fluid was drawn from the tube in the abdomen every hour; after that every two hours, and it was removed on the second day. She ate and slept well during her stay at the hospital, and her bowels gave us no trouble. In short, her case was no more difficult than that of most any abdominal section. Her temperature, except on one evening, did not rise above  $101\frac{1}{2}$ , which was no higher than that recorded on her admission. The external dressings were changed once or twice during the twenty-four hours, and on the fifth day the packing was removed from





**Appearance of the Wound at the Sixth Week.**

the sac, the patient turned on her side, and the cavity thoroughly washed out from the bottom with a ten per cent. solution of peroxide of hydrogen. The cavity was rewashed and packed every twelve hours until the sloughing, which was excessive, considerably subsided; then the dressing was done once a day. The wound rapidly filled up from the bottom, and she was discharged from the hospital the seventh week after the operation. The wound was completely healed three months after the operation and she had gained thirty-five pounds. Twenty-one months have now elapsed, and although she has had two criminal abortions, she remains well and hearty.

CASE II. Mrs. H. P., Victory, N. Y., age thirty-eight years, married, mother of two children, through the kindness of Dr. Sweeting of Savannah entered the Rochester Homeopathic Hospital October 31, 1891, and gave this history: Her own family and its branches for three generations were remarkably rugged and healthy. Her gestations were normal and her deliveries easy. Her last child was five years old, and her menstruations were regular until August 8, 1891. She then flowed  $2\frac{1}{2}$  days, when the discharge was believed to have been suppressed by getting her clothing wet through in a rainstorm while berrying. Her next menstrual period was protracted to thirty-three days, and it was accompanied by severe pain in both groins, which lasted many hours. There was nausea and vomiting, cold sweat, pallor, and collapse, followed by so-called after-pains and a bloody vaginal discharge. Hot applications were made to her feet and bowels, and she was partially relieved, yet there remained pain and soreness for which she was obliged to take morphine occasionally, until after the operation was performed, when she was promptly relieved. With each attack of pain the flow increased, and it became almost constant. At first it was bloody, and clots were frequently expelled, then it became watery, and when she entered the hospital the discharge

was dark red or blackish and very offensive. About two weeks after the first illness, *i. e.*, when the tube probably ruptured, a fleshy, white membrane was found in the vessel. There was no special pain during its delivery, but there was an unusually profuse bloody flow. The patient was very fleshy, weighed two hundred pounds, and the diagnosis, even by aid of chloroform, was made with difficulty three days before the operation, which was performed at the hospital November 3, 1891, fifty-one days after rupture of the tube into the abdomen.

The sac was nearly covered up by the coils of adherent intestine and omentum; in fact, these structures and the adventitious tissue which bound them together walled off the clots, placenta, and other products of conception from the abdominal cavity. Consequently when an effort was made to free these adhesions the sac was ruptured, and a quantity of dark blood and clots was discharged into the wound. These and as much of the results of conception as could be peeled off with safety were removed, and the balance left undisturbed. The abdomen was thoroughly irrigated, and a large glass drainage tube carried down to the bottom of the sac. There was an unusual amount of exudation from the lacerated and inflamed surfaces, and it was not until the sixth day that it had diminished sufficiently to safely remove the tube. The wound healed by the first intention, except where the drainage tube was retained, and of course this opening was left to fill up by granulation. About the third week, while changing the dressings, a gurgling sound was noticed, which was followed by a discharge of fæces from the wound. This became quite copious, and kept up, more or less, until her discharge from the hospital March 30, 1892. In a letter received from her a year after the operation she states that the fistula closed soon after she left the institution, and that she remains perfectly well.

CASE III. Mrs. —, age thirty-seven, widowed six

years, entered the hospital January 25, 1892. She had had three children, the oldest thirteen and the youngest seven years of age. Her first confinement was very difficult; the cervix was lacerated and the perineum horribly ruptured; but there appeared to be no symptoms from these injuries until after her last accouchement, since when she has suffered "bearing down" and pain in her sides, especially at her menstrual periods. Examination revealed a bad rectocele and cystocele. There was constipation, and she was obliged to reposit the bladder before she could micturate. A mass could plainly be felt in the left iliac fossa, and although chloroform was administered I was not able to make a diagnosis on account of her great size and weight—250 pounds—and thick abdominal walls.

About two months before, however, she had severe pain in the left ovarian region, followed by collapse, and was obliged to remain in bed. She admitted to me that she had a friend with whom she had intercourse frequently. The physician in charge apparently did not comprehend the situation, as he regarded the malady as a fainting spell due to female weakness, and expected to cure her by trachelorrhaphy and colpoperineorrhaphy, which he promised to do when she sufficiently recovered. She bled constantly; as she expressed it, "always had bloody discharge between the menses." Her temperature was 102°, and it was apparent that there was an accumulation of pus in the pelvis, and of course abdominal section was decided upon as the only rational mode of treatment. An opening into the peritoneal cavity through nearly six inches of adipose tissue exposed a sac which appeared to be of an extra-uterine pregnancy. Coils of intestine and the omentum were united to the sac, as in the foregoing case, and concealed it from view. The sac was broken into by the attempt to separate the adhesions, and a large quantity of dark, bloody fluid and clots removed, together with unmistakable products of gestation, which had suppurated and

developed considerable pus. The cavity of the abdomen was thoroughly flushed out, and the wound closed with a glass drain placed down to the bottom of the sac. Owing to her enormous weight, thick abdominal walls, together with the infection of the abdomen from the pus, we scarcely expected her to survive the operation. Yet she did nicely, and recovered without any alarming symptoms whatever. Her pulse varied from 75 to 100, temperature from normal to  $100\frac{1}{2}^{\circ}$ . She left the hospital the sixth week greatly improved in health and strength. She has a good appetite, sleeps well, and has no pain. Her menstrual periods last from three to five days, and they are without suffering, and she considers herself well.

CASE IV. Miss —, age twenty-two, occupation dress-maker, had been well up to May 2, 1892. At this time her menses "skipped," and when they appeared the flow was alarmingly profuse, with discharge of clots and a membranous sac. She was taken to the City Hospital, where a competent surgeon diagnosed a tumor in the left ovarian region, and proposed abdominal section, which she refused, and left the institution. Three days later I was called, and she stated that just after she left the hospital she had a sharp, tearing pain in the left ovarian region, which was accompanied by great prostration, pallor, and a cold, clammy sweat. When I saw her she had rallied from this condition and appeared very anæmic. Examination failed to reveal any tumor, and she was sent to the Rochester Homeopathic Hospital, where she rapidly improved; yet there was considerable oozing from the uterus. Another careful examination under chloroform did not reveal pelvic disease, and curetting was done, which arrested the slight hemorrhage. She was discharged from the hospital a few weeks later quite comfortable, and was able to go about the city as before. Six weeks later, however, she called at my office, and examination showed a tumor which could be seen and appreciated by palpation both through the vagina

and abdominal walls. She denied that she had had intercourse at all, yet confessed she had a gentleman friend who would pay her necessary expenses, and care for her needs while at the hospital.

This history, with the rapid development of the tumor, made me suspect that she suffered from tubal pregnancy; that her first surgical attendant felt the tumor before rupture had taken place; that I saw her three days or so after the rupture and was unable to diagnose the condition, even when the patient was completely relaxed by an anæsthetic. This seems very strange, but the tube ruptured into the abdomen, and the blood must have been fluid, so the examining fingers could not appreciate the condition until the mass was walled off from the abdominal walls and encysted. In a similar case I would now open the abdomen, with nothing but the history and subjective symptoms as a guide to the diagnosis. This plan would save much suffering and many lives. The only drawback to it is the opening of an abdomen, once in a great while, where no pregnancy exists, and, in the light of our present knowledge, if due care be observed, this would almost never occur. In this case, during the thirty-five days which elapsed between the rupture of the tube and the abdominal section, many strong adhesions were formed, and the operation thereby was rendered very difficult. Although it required but a few minutes to make the section, and she was out of her bed only thirty minutes, she well nigh lost her life from shock. The pulse was very rapid and scarcely perceptible, the countenance was pinched and deathlike; in short, her whole appearance was like that of deep collapse. A chair was placed under the foot of the bed, to elevate it, and the following enema given every four hours:

Chloride of sodium.....	grs. xlv
Bicarbonate of soda.....	grs. xv
Brandy.....	℥ i
Water.....	℥ xii

She finally reacted, and the functions were normally performed on the third day. Large quantities of bloody serum was drawn from the drainage tube, which was removed on the third day. She made a good recovery, and was discharged from the hospital the sixth week, and remains well.

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## ALOPECIA CALVA DURING PREGNANCY.

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BY

W. SCOTT HILL, M. D.,

AUGUSTA, ME.

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THE following case occurred in my practice. A young woman of scrofulous diathesis becoming pregnant with her first child began very soon to grow anæmic and very weak. She had previously been an active, hard-working woman. About the beginning of the third month she noticed that the hair of her head began to fall out; this continued until she was  $5\frac{1}{2}$  months pregnant, when she miscarried of a dead child. At this time there was complete loss of hair of the head, eyebrows, eyelashes, and of the external genitals. Soon after miscarrying the anæmia improved, her hair began to grow, and she returned in a few months to her usual good health.

Ten months after her miscarriage she a second time became pregnant; all the conditions of her first pregnancy were repeated—anæmia, weakness, and loss of hair of the whole body. She miscarried at  $6\frac{1}{2}$  months. The child was alive, but died within twenty-four hours. She at once began to improve. As before the anæmia disappeared and the hair again grew. There was no known constitutional taint to cause it, nor was it hereditary.

## A CASE OF HYDRAMNION AND ACRANIA MONSTROSITY.

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BY

E. B. LAMBERT, M. D.,  
PORT JERVIS, N. Y.

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**D**URING the month of June, 1891, I was called to attend Mrs. P., age thirty-six, American, in her seventh confinement. The messenger urged my immediate attendance "because the woman's stomach was any minute likely to burst."

I found the patient, with an enormously distended abdomen, sitting on the edge of the bed. She informed me that she was unable to lie down on account of the difficulty of breathing in that position.

Believing I had a case of hydramnion to deal with, I stepped into an adjoining room to wash my hands prior to making an examination. During this time she expressed a desire to urinate, and with that purpose in view was assisted upon an empty wooden pail, when the amniotic sac spontaneously ruptured and discharged its liquid contents into the vessel. I afterward carefully measured this liquid, and found it to be over nine quarts.

The patient was hastily put to bed, and inside of ten minutes an acrania monstrosity was born. It lived about five minutes.

The child was a male, weighing nine pounds. The bone and scalp at the vertex, extending from the coronary to the lambdoidal suture, was wanting. Through this opening the cerebrum with its membrane protruded. This mass is imperfectly shown in the cut. There was an extreme anterior and lateral curvature of the spine. Two teeth were erupted, and the ears were nearly double normal size. The mother has since give birth to a healthy child.





## THE BABY-FOOD QUESTION.

BY

GEORGE WILLIAM WINTERBURN, M. D.,  
NEW YORK.

THE question of the artificial feeding of infants is one that demands answer every day of our lives. The general practitioner is constantly asked: What is the best baby-food? If he has had much experience he will be wary of his answer, well knowing that one baby will starve and another will thrive on the same food. As for myself, I have, during the past score years, run through the whole gamut of patent foods, and the mere fact of my doing so shows the state of my mind regarding them. There are many very good foods on the market. Each one of these will agree perfectly with a certain number of babies, but none of them will suit all babies; and the man who can determine offhand whether the baby will thrive or starve on a particular brand of prepared food is wiser than I.

The makers of infant foods present us with chemical tables showing that their particular food closely resembles mother's milk. But there is one element in mother's milk which is absent from all these prepared foods, and which defies chemical analysis—the vitality. Milk as it comes from the breast is alive. It conveys to the child not only certain necessary chemical constituents, but something of the mother's own life. It is impregnate with her own emotions and mental states. For the development of her babe nothing can fully replace it. Cow's milk when perfectly fresh is the best substitute, but it must be used while yet warm from the udder. As soon as it gets cold it is dead, and is then only a chemical compound. As a chemical compound it differs essentially from human milk, and is not an ideal food.

To those of us who live in cities milk fresh from the cow is an impossibility, and bottled milk is often a delusion and a snare. It is to the undesirability of cow's milk as a substitute for human milk that I desire to call attention. This is not a new question, but I have a suggestion to make which may be useful. This suggestion is the result of considerable experimentation, and I offer it as a solution of a most difficult problem.

Cow's milk in the proportion of its proteids, both coagulable and non-coagulable, fat, salts, carbohydrates, and water, differs from human milk, as also in the character of some of its constituents and in its reaction. So to make it approximate to human milk it has been recommended to :

1st. Make it alkaline in reaction.

2d. Dilute it with water to diminish the percentage of coagulable albuminoids.

3d. Add to it some matter that will intimately incorporate itself into the casein as it falls in the stomach, preventing formation of curds, and allow the gastric juice to attack it from all sides and convert it into peptone. This is generally starchy matter, oatmeal water, barley water, gelatine, etc., etc.

4th. Bring up the percentage of sugar, or carbohydrate strength, by adding sugar of milk.

5th. At times partially predigest the casein before it enters the stomach.

6th. Sterilization.

While by these methods it can be made to approximate in its character to human milk, there are still apparent certain variations. The addition of water to reduce the amount of casein in no way insures its digestion ; it simply lessens the quantity and at the same time diminishes the proportions of the fat and the salts, as well as the already too little milk sugar, and augments the water, thus increasing the food bulk to a point beyond a child's power to take and hold, let alone the question of assimilation and

nourishment. It has been calculated from analyses of cow's milk that it takes two parts of milk and one part of water to give a food representing proteids 3.5, hydrocarbons 3.+, salts 0.2+, carbohydrates 4.+, water 88.+, the requisite amounts to support the young infant's life.

And the young infant can only manage :

One part milk and two parts water.

So to bring it to the proper standard we must add a soluble carbohydrate, and none is better than the old-fashioned dough or flour ball ; or, in other words, the inside chalk-like mass, soluble dextrin, formed from continuously boiling for, say, fifteen hours, a quart of good winter wheat flour, packed very tightly in a twilled, unbleached muslin bag. Before removing the bag let the mass rest or drain for some eight hours. Then cut off the bag, scrape away the soft or outer rind of dough, disclosing the inside chalk-like mass, soluble dextrin, this to be scraped or grated, and used as wanted, remembering while it is more or less bother to make, yet when once made it can be kept for a long time, proper care being taken to keep it in a clean, closed, dry receptacle. It is well before putting the flour bag into the boiling water to dip it thoroughly into cold water and then dredge a thin layer of flour around the muslin flour ball, so that in the long boiling the mass does not become soggy through rapid infiltration with water. Remember the water during this entire fifteen hours must be boiling hot, and there must be *plenty* of it, enough to cover completely the submerged bag, and when, by evaporation, the water runs low, it must be replaced by boiling water ; by all means do not add cold water from time to time. We are thus able to feed, not insoluble starch, but soluble starch, non-irritating and at the same time not predigested. The child changes this soluble starch or dextrin into maltose and dextrose, and does not throw it off as it would insoluble starch, such as arrowroot, oatmeal or barley dust,

cracker powder, etc. Soluble dextrin, instead of retarding the action of the gastric juice, as does limewater, soda bicarbonate, potash bicarbonate, etc., acts as a peptogen, exciting the flow of the gastric juice, and the pepsin thereof takes hold of the proteids and converts them into peptones. I desire to express my strong disapproval of predigestion of proteids. A young child is capable of physiologically transforming proteids into peptones. By changing proteids into peptones we not only offer the child a bitter mass (often leading to its refusal), but also run the risk, if too long continued, of causing atrophy of those glands secreting digestive juices interested in such conversion. The curd of cow's milk must not be predigested, even though it does cause hard, dense coagula in the child's stomach, which the digestive juices with their enzymes can permeate but slightly, setting up irritation, as would a stone, cellulose, woody fiber, spiculæ, etc.; we must break up this curd, causing it to fall in floculi, easily digested, as is the case with those of mother's milk in the stomach. The boiled flour of the dough ball and the saccharated maltose of proteinol so act, analogous to the bread crumbs in the suet pudding of the dyspeptic adult.

If we added insoluble starch we would transgress the well-known law: The young infant cannot manage (except in rare cases, all knowledge to the contrary notwithstanding) insoluble starch—that is, as far as mouth digestion is concerned, as there is no ptyalin for the first few months of life; furthermore, uncooked starch granules are surrounded by a covering of cellulose, which is irritating. This insoluble starch irritates the mucous glands of the stomach, much mucous is thrown out, hydrochloric acid is formed in excess, fermentation is set up, lactic acid in excess is formed and passes into the blood, dissolving out the earthy phosphates from the tissues.

I would therefore suggest for the perfect maintenance

of a healthy child, say four weeks of age, where there is no vomiting, no diarrhea, simply a history of the mother having no milk, and a wet nurse not to be had :

1 teaspoonful of soluble dextrin (made as stated above).

1 teaspoonful condensed milk (must be rich in fat, have a fair amount of sugar, and plenty of water).

30 drops proteinol.

24 teaspoonfuls water.

An analysis of this, and an analysis of a healthy, normal, average, human milk for a child of the same age, yield exactly the same result. Proteinol is made from the entire egg, digestible fat, brandy, and saccharated malt. The addition of the 30 drops of proteinol brings the fat standard from 24 parts in 1000 to the requisite 40 parts of fat in 1000, and at the same time gives the great proteid or tissue builder albumin, as well as the stimulant and energy making maltose. The value of the above combination lies largely in the fat ; search it thoroughly and no adventitious chemicals are found present.

Proteinol contains brandy, and I am averse to the use of alcoholic stimulation in patients of every class. But the mixture recommended contains alcohol only in the ratio of 1-312, and is indistinguishable either in taste or effect. The brandy used in proteinol is of the very highest grade, and is imported especially. Condensed milk is urged. Theoretically it is not the fresh, living, antiscorbutic material fresh cow's milk is supposed to be. But as there is no question as to its being aseptic, its casein is easier of normal digestion, and the continuous use of the same brand gives the same results irrespective of temperature and place. Dairyman's milk is not always convenient ; furthermore, is not certain any number of days in succession, notably during the summer season. Moreover, condensed milk has a fair complement of water, thus differing from dried milk foods, consequently has not lost its antiscorbutic property.

The sterilization of milk is in no way considered, inasmuch as:

We are beginning to learn that the chemical changes induced in milk by sterilization are much greater than was supposed. The chief changes now known are the following: (1) As regards the destruction of germicidal power, careful experiments have shown that when a known number of disease germs are placed in fresh milk, there will be a less number to be found at the end of three hours than at first. Not so if it has been sterilized. (2) The lactalbumin in the milk, which is closely allied to serum albumin, is coagulated by heat, whereby the milk is rendered more viscous. This albumin is thus rendered less soluble and seemingly more difficult of digestion, and is the cause of change in the flavor of the milk. (3) The starch-fermenting power of the raw milk is lost, a property of value in the digestion of an infant, whose saliva has not yet acquired that power. (4) The milk sugar is changed, undergoing a degree of caramelization. (5) The fat in the milk is more or less freed from its emulsion, so as even to be found sometimes collected into drops upon the surface of sterilized milk. As the fat must be in an emulsion to be absorbed from the intestines, the digestive organs have the task of restoring this. (6) The casein is also affected, as proven by its being less easily and completely precipitated by rennet. According to Baginsky it requires more rennet and a higher temperature, and according to Soxhlet the addition of some lime salt. In experiments of artificial digestion the casein is found to be less readily acted upon by pepsin and pancreatin. Milk, therefore, which has been sterilized is certainly no longer the original natural product in other respects than being free from bacteria.\*

On the other hand, there is to be considered the fact, sterilized milk is clean when it is in clean receptacles, and

\*New Jersey State Dairy Commission Report upon "The Preservation of Milk," 1892.

can be kept aseptic twenty-four hours—a great advantage where the case is one where overcrowding, ignorance, heat, and filthy habits combine to make the already poor dairyman's milk septic. If, after due deliberation, sterilized milk, rather than the more handy and valuable condensed milk, be adopted as the base, the addition of the proteinol and the soluble dextrin, in the proper proportions, having in mind the chemico-physiological changes superinduced in milk by sterilization, makes the complete food necessary for perfect metabolism.

How much food altogether must be given combined in these proportions? For the first month the child should have the equivalent of 16 to 24 ozs. of human milk; in the second month the equivalent of 24 to 30 ozs; in the fourth month 30 to 35 ozs., and later 35 to 40 ozs. or more. These quantities are not absolutely or arbitrarily fixed. They are to be varied within the limits named according to the capacity of the child and its peculiarities. The child's stomach acts, in some degree, as an indicator of quantity too. If overfilled the excess is readily rejected. If after the meal craving still remains the child cries for more, sucks its fingers, is restless and complaining. With the data given, and a watchful observation of the child's condition, aided by a regular record of weight (the increase should be two or four ozs. per week, or more), the necessary quantity will be estimated with sufficient exactness. As the child gets over the four weeks of age the formula calls for, the doctor will, according to the condition of the child, increase the amounts of the boiled flour, proteinol, and condensed milk. Remembering this amount of water only applies to healthy children, where diarrhea, vomiting, etc., it is advisable to increase the amount of water to as many as sixty teaspoonfuls, keeping intact the other ingredients, even if the sick child is two, three, or even six months old.

In serious cases of marasmus, cholera infantum, etc., we



would advise omitting all food save proteinol, commencing with 20 drops and quickly increasing to dessert- and even tablespoonful portions to a child as young as three months, as often as every two or three hours. It is retained, it builds firm, muscular proteid, and not carbohydrate, flesh very rapidly. The argument that a certain food agrees is all right if that food contains in due amount the proteids, fats, salts, carbohydrates, and water. But if it does not have these constituents in proper proportion, while it may do to bridge over a temporary trouble, its standard is below that requisite to the health and strength of the child. Above all, do not take a delicate little infant with a stomach whose powers are utterly unequal to digesting the coarse, heavy curd of cow's milk, shown by the vomiting, purging, emaciation, etc., and put it forthwith on goat's milk, as the casein of goat's milk coagulates in equally heavy masses, and the change, instead of bettering, makes matters worse than at first. Again, do not take a puny, bloodless child with incipient rickets, evidently suffering from want of protein and fat, owing to its supposed inability to digest cow's milk, and place it upon a purely farinaceous diet, thus causing a still further deterioration, inducing scurvy in addition to rickets. If we use improper foods, not commensurate with the chemico-physiological wants of the growing child, both as to quantity and to quality, in the future we will have a poor, rachitic, pot-bellied weakling, with large head, sweating easily, peevish and fretful, and we will set up a diathesis that will with difficulty, if at all, resist the inroads of disease.

## THLASPI BURSA PASTORIS.

BY

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PATIENT, Mrs. J., at climacteric had been subject to severe uterine hemorrhages for six months. I had given the usual styptics, secale, china, erigeron, geranium, and bell., as each had at times been indicated, but with no lasting effects.

One day in looking over some back numbers of the HOMEOPATHIC JOURNAL OF OBSTETRICS I came upon a proving of capsella bursa, recorded by Dr. Phil Porter, he having used it with good results in a similar case. I immediately provided myself with the remedy, and at her next menstrual period I prepared the remedy as directed by Dr. Porter: 15 drops in a half glass of water, a teaspoonful to be given every hour. It controlled the hemorrhage and produced a severe constrictive headache. Patient said it seemed as though her skull would crack if she did not move her head with great care. Glonoine high removed the headache, and again produced the hemorrhage. I tried this for a few times, stopping hemorrhage and producing headache, relieving headache with return of hemorrhage. I finally decided to try 5 drops 1x in a half glass of water, a teaspoonful every hour; this with decided improvement; in a few hours a perfect control of the hemorrhage, and no headache. There has been no return of hemorrhage, and six months have now passed. There is, however, a decided improvement in the general health and appearance of patient.

This remedy does not act upon the muscular fibers of the uterus, causing contractions to eject from that organ any foreign substance, but acts upon the muscular coats of

the blood vessels through the entire system, thus causing contractions of the blood vessels, thereby re-establishing the normal circulation. It also, by contracting the blood vessels, causes a reduction in size of an enlarged and hyperplastic uterus, thus reducing the size of the abdomen, and giving the patient a much lighter feeling in walking and of easier navigation.

I have used this remedy in three similar cases of hemorrhage at climacteric with gratifying results. Also some cases of hematuria associated with troubles at climacteric with prompt relief and cure.

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#### A SUGGESTION.\*

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BY

SOPHIA PENFIELD, M. D.,  
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TWENTY years ago Dr. Carrol Dunham said: "Women's diseases constitute a large share of our cases, and yet here our materia medica is weakest. Few women have been provers of drugs, and those, as a rule, have been deficient in definite knowledge of the human system, and are therefore incompetent observers. These provings to be valuable should be made by women medically educated. If women physicians should seek admission to the privileges of our profession I could not imagine a more complete vindication of their right than such a contribution to human knowledge would be."

In the twenty years that have past since those words were written new remedies have been proved by women, and old provings have been confirmed, but the weak spot in the materia medica remains. Women's diseases still

\*Read at the annual meeting of the Connecticut Homeopathic Medical Society, May, 1892.

constitute the majority of our cases, as the army of sufferers from distressing maladies peculiar to our sex bears witness.

In these twenty years, surgical resources have seemingly outrivalled medical cure, and when a crisis comes in a woman's life, to choose between laparo-hysterectomy, life-long misery, or death, the skill with which the operation can now be performed gives hope to the victim.

We prize the skill of progressive surgery, but far more, we need a medical knowledge that shall obviate the necessity of so many capital operations upon women.

Experience daily teaches us how slight is the primary cause of uterine disease. A simple inflammation of the mucous lining from exposure or irritation of the pelvic organs, neglected because painless or only annoying, or from fear or false modesty, when grafted upon susceptible tissue, extends gradually along the mucous linings toward the uterine appendages, and develops a salpingitis or an ovaritis, or, encroaching upon the deep muscular tissues, evolves a metritis, and lo! a foundation is laid for a tumor, a polypus, pyosalpinx, epithelioma, or it may be a scirrhus.

It is wise for us to search persistently along the avenues of disease, from uterine catarrh in its mild form as the source to cancer in its malignant aspect as the terminus, for remedies indicated in the various stages.

We all believe in the law of similars. We have applied it with success in the treatment of catarrh in the nasal, bronchial, and gastric passages. It is reasonable to infer that, as a catarrh of these passages is amenable to cure in any of its stages, uterine catarrh, a disease of like nature, is subject to the same law.

What we now want are provings of certain remedies upon the pelvic organs of woman. The need demands it. A united, systematic work each year upon certain remedies of special action upon the generative organs of woman would bring results that would give inspiration to ourselves and hope to our patients.

To select one or two remedies well known for their special action, but not well proved, and each bring the experience a year will lend from provings on the healthy, or from experience with the same remedy among the sick, will add new value to the materia medica and help to arrest intricate cases of diseases of women in their early stages.

For example, *hydrastis can.*, a specific in certain gastric and nasal catarrhs, and indiscriminately used externally and internally in uterine catarrh, has only the most general of provings upon women, and those are not yet entered in the encyclopedia, but are found here and there scattered through smaller works and journals.

How indefinite are the details!

A profuse, yellow, tenacious leucorrhœa after menses, pruritis, ulceration of cervix, cancer. What are the characteristics and indications for ulceration, and how do the cures of cancer average?

*Helonias* possesses great affinity for the uterine organs, but it has few provings. Its general summary is a uterine tonic for worn-out women, for hemorrhages, and for debility. What is more needed than such a tonic?

But women are individual, and so are remedies, and the drug characteristic can only fit the individual by proving.

In *sanguinaria* one of its meager provings on uterine organs is mucous polypus.

How great a proportion of removals, and what are the indications of this powerful remedy?

In *senecis* we find a remedy for nervous, desponding, anæmic women, and in *viburnum* a remedy for dysmenorrhea, but what can we find individualized concerning these remedies?

How wide and far-reaching is the action of any one of these partially known remedies, and what diseased states they may be able to subdue, or what tendencies to overcome among women they alone can prove.

Let us each contribute our yearly experience and strengthen this weak spot.

## THE OPERATION FOR SHORTENING THE ROUND LIGAMENTS, WITH REPORT OF A CASE.\*

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BY

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WHEN the Alexander Adams operation was first introduced it was quite the fad for a time. Of course it was injudiciously used and greatly abused, and in consequence received a bad reputation. It seems a most peculiarly general fault in an otherwise admirably well balanced class of men that new measures in medicine and surgery should be run to such irrational extremes. That the operation for shortening the round ligaments has its place in gynecological surgery is, however, now well established. Such a conservative surgeon as Mundé gives it a leading position among the various operations for correcting displacements of the uterus. Then, again, Edebohls of New York, and Neuman of Chicago have so modified, or rather, perhaps, amplified, the original operation that it is much easier of performance and more reliable in its issue. In the original Alexander operation the incision was made only over the pubic insertion of the ligament, and the efforts to find the frayed out ends of the ligaments often proved entirely unsuccessful; or if found they tore upon tension. Edebohls and Neuman overcame these difficulties by laying open the entire inguinal canal.

The operation is contra-indicated in any displacement of the womb complicated by acute peri-uterine inflammation, or where the uterus is bound down by old adhesions. In other words, it is applicable only where the organ is freely

\* Read before the Southern Homeopathic Association, Hot Springs, November, 1892.

movable and can be lifted up in the pelvis. Then, also, too much must not be expected of the operation in itself. In many cases other plastic operations must be performed—trachelorrhaphy, perineorrhaphy, colporrhaphy, or perhaps all of these combined. The case recorded below was such an one. Dr. Edebohls advocates the doing of all such accessory operations at the same sitting with the main operation.

CASE. Mrs. N. had been more or less of an invalid for several years; age thirty-two, two children, aged five and seven. I began treatment by doing necessary rectal work. For some time she improved, then began to fail; menstruation much disturbed, heavy dragging in the pelvis, headaches, debility, etc. The uterus was double the normal size, entirely retroverted and retroflexed, and very low down in the vagina, but freely movable. The vagina was exceedingly dilated and boggy; had much trouble with vaginal flatulency. Cervix and perineum both lacerated. I now repaired the cervix and perineum. Again we had improvement for a time. At last it became apparent that some means must be devised to replace and hold the uterus in its normal position. Pessaries of all kinds and sizes were tried without success. The patient therefore consented to submit to the further necessary operations. The only dread was the anæsthetic, which seemed to make her more deathly sick after each administration. On this account I gave her chloroform alone, with all the preliminary precautions of dieting and clearing the intestinal tract. I first performed an anterior colporrhaphy, and then shortened the round ligaments by Edebohls' method.

Having shaved the pubes and cleansed the integument, an incision was made, beginning at the pubic spine and extending  $2\frac{1}{2}$  inches upward and outward parallel with Poupart's ligament. The inguinal canal having been well laid open on a grooved dissector passed into the external ring, the bottom was carefully searched with a blunt hook,

and the round ligament readily caught and separated from its attachments. It was then drawn out, four inches cut off, and the remainder stitched into the canal by passing through its center the same silkworm gut sutures that brought together the walls of the canal and flaps of the wound. The precaution was taken to insert four or five strands of the gut sutures for drainage. The other side was treated similarly, and the whole dressed with the ordinary antiseptic dressing. A digital examination showed the heavy uterus drawn high up and anteverted into the pelvic cavity. No intra-uterine stem nor pessary was ever applied.

And now began the worst case of nausea and vomiting I have ever seen. The constant and severe retching strained the wounds dreadfully, and of course produced very great pains. This continued for upward of a week, and I really feared I would lose my patient from exhaustion. I could not imagine a more trying test of the strength of these ligaments and the ability of their new connections to withstand the strain than that which they were subjected to in this case. They stood the test perfectly: they did not apparently give one iota, and the wounds healed strictly by first intention.

There have been many complications in this case, on account of which she is yet by no means a well woman; but so far as the operation for raising and holding the uterus is concerned I count it a success; the organ is now, after a year, in apparently the same position as immediately following the operation. I considered it worthy of record because of the unusual test and the successful issue. The truly judicial surgeon will always keep it in resource for cases demanding radical procedures.



SOME OF THE USES OF ELECTRICITY IN  
OBSTETRICS.\*

BY

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ELECTRICITY in its various forms has been recommended as valuable in obstetrics since the early days of this century, but owing to cumbersome and unportable batteries it has not been practical to use it. Now, however, with so many of the improved dry cell batteries that can be slipped in an overcoat pocket or an obstetric bag, and a good current obtained without trouble or loss of time, electricity will many times prove to be a valuable aid in the lying-in room.

Not all the little pocket batteries, however, that can be found in the shops are serviceable or of much value. Care should be taken in selecting a battery for obstetric purposes to get one that will give a good, strong, and even current, one that is smooth and free from jerks. To be of the greatest service the battery should be provided with two adjustable induction coils, one composed of relatively short, coarse wire, the other a coil of long, fine wire. These will give two distinct currents that are of great importance to the obstetrician. First, the current of quantity from the short, coarse wire, which is a stimulant and muscle contractor, and the long, fine wire gives a high tension current with sedative effects. A great deal of success depends on the right selection of the current.

The electrodes that are needed by the accoucheur are a thin, flat piece of copper or zinc, about three inches wide by four inches long, with a cord connector soldered to one

\* Read before the New York State Homeopathic Medical Society, February 14, 1893.

side. The connecting cord attached to this electrode should pass through a piece of rubber tubing. An ordinary flat sponge electrode covered with sheet rubber with band to go over the hand to assist in holding, a ball vaginal electrode, a bipolar uterine electrode, and an ordinary sponge electrode with handle may be useful at times. This apparatus may all be carried in an ordinary obstetric bag, together with the other appurtenances of the obstetrician.

No particular skill is required to use the faradic current upon a parturient woman, and this is about the only current that can be used with any practical value. The flat copper electrode should be wrapped in a layer of wet absorbent cotton, and this secured to the back of the patient by a roller bandage. The connecting cord, protected by the rubber tubing to prevent soiling by any of the discharges, should be long enough to allow the patient perfect freedom to roll about or change her position as she chooses. The current can be passed to the uterus through the abdominal walls, either with the use of the flat sponge electrode or through the operator's hand, the connecting cord being attached to the wrist by a metallic band. The hand makes a very serviceable electrode, with one or two objections. It is tiresome to the operator, and to persons susceptible to the electric current it becomes exceedingly painful, especially if very strong currents are used. The advantages are that the operator knows exactly and all the time just the kind and amount of current the patient is getting. He can insinuate the hand into the abdominal walls and about the uterus better than any other kind of electrode, and if it be for inertia of the uterus following labor, the uterus can be kept in the grasp of the hand until the desired effect is obtained.

Electricity can be used in many cases with good results for its sedative effect. A high tension faradic current has been shown to have a marked sedative action bordering on

a local anæsthesia. This can be easily demonstrated by passing a high tension induced current through the hand or finger. This can be made useful in many cases of minor surgery. It can take the place in a measure of the local use of cocaine.

In many cases during the tedious stage of dilatation the high tension induced current will work brilliantly. Where the old school physicians, and, I fear, sometimes those of the new school, put in their doses of morphine and chloral, this current will do all and more than the drugs. It is under the immediate control of the physician, and can be continued or discontinued at will. While it quiets the patient and eases those nagging pains, there is no arrest of uterine contractions, but it will often convert an irregular, inefficient pain into a regular businesslike baby producer.

Electricity increases the force of uterine contractions.

Dr. Ludlow, in a paper read before the American Medical Association, says: "If there be one action of electricity more certain than another it is its power to evoke and stimulate uterine contractions." Hence if we are dealing with a tedious labor from lack of uterine muscular tone, if there is a disproportion between the maternal parts and those of the fetus, if the woman is weak and debilitated from any cause, if she is nervous and irritable, and won't try to help herself, and "bear down," if it has been your custom to "throw in a dose of ergot to hurry things a little"—in any of these emergencies, to those who will try a good, steady, high tension current, they will be surprised many times by getting results that will be satisfactory to themselves and pleasing to the patient.

Electricity may be of use in the expulsion of the placenta. If from thick abdominal walls or over-sensitiveness of the female the expression of the placenta by the Credé method is unavailing, an application of the faradic current for a few minutes will stimulate uterine contractions and the placenta is speedily delivered.

Electricity can be used with remarkable success in *post-partum* hemorrhage.

It is here that the selection of the current is of the utmost importance, and where the practical distinction between a current of quantity and a current of tension is clearly demonstrated. The old method has been to place the negative pole over the abdomen and the positive pole over the sacro-lumbar region. This method answers very well in mild cases of hemorrhage, without paying much attention to the kind or quality of the current.

More recent investigators, among whom is the celebrated Apostoli of Paris, have shown that a current of tension produced marked contractions on the surface of the body. When one pole was placed internally, the external pole produced strong contractions, while the internal was hardly felt. A current of quantity, while producing but faint, if any, contractions when used externally, gave evidence of very strong contractions when used internally. Here are some electro-physiological facts that are not well understood, and until the various phenomena of electro-physiology have been more clearly demonstrated we must accept the facts without the explanation. We know that muscle contraction depends on electro-motive force, and that the greater the current quantity the greater the electro-motive force. Current tension depends on current resistance. A current of quantity placed within a relaxed and atonic uterus by the bipolar method gives a current with great electro-motive force and a minimum of resistance. The effect is an immediate strong uterine contraction, which has been proven by bedside experience to be a sure, safe, and effective remedy for a *post-partum* hemorrhage of the severe type.

Electricity has been used with success as a galactagogue. Faradization may be used with dry electrodes or moist ones. Good results have been obtained by both methods.

Dr. Blackwood, in the *Philadelphia Medical Times*,

reports three cases in which he obtained an abundant secretion of milk by the use of static electricity. He passed sparks through the breasts daily. His results were no doubt due to the mechanical stimulation.

If the obstetrician is supplied with a good battery in the lying-in room it may often be useful in stimulating respiration in a stillborn child. The faradic current should be passed along the course of the phrenic nerve. It will often prove efficacious when all other means have failed.

Although I have given but a very incomplete picture of the various uses of electricity in obstetrics, I hope I have been able to show that the agent destined to propel all of the many mechanical devices of man can also do much toward making his advent into the world easier and less dangerous to both parent and offspring.

As a fitting closure I think I can do no better than to quote the conclusions of M. Apostoli in *Gazette des Hôpitaux*, from a total of five hundred electrizations of the uterus:

"1st. Faradization of the uterus is entirely harmless.

"2d. Faradization is a uterine sedative.

"3d. Faradization abridges considerably the convalescence and accelerates the involution and retraction of the uterus. That it also hastens the restoration and promotes regularity of function.

"4th. Faradization guards the woman from the uterine complications of labor.

"5th. That faradization is the correct preventive treatment of uterine malpositions.

"6th. The action of faradization on the uterus is similar to that of ergot, only its action is more prompt and more energetic.

"7th. It is a marvelous therapeutic agent in obstetrics, simple in application, rapid and energetic in action, perfectly harmless, and can be interrupted or renewed at will. It not only restores the uterus to a normal condition, but its use prevents further uterine complications."

CONGRESS OF HOMEOPATHIC PHYSICIANS AND  
SURGEONS.

## SECTION OF GYNECOLOGY.

The section was called to order at 3 P. M., Wednesday, May 31, 1893, in the Hall of Washington, Art Palace, Chicago, by Dr. R. Ludlam of Chicago.

O. S. Runnels of Indiana, chairman of the section, delivered his inaugural address as follows :

THE SINE QUA NON. BY O. S. RUNNELS, M. D.,  
INDIANAPOLIS.

The danger that confronts every specialist is a too intense and contracted specialism. Having a circumscribed field of operation, a portion only of the physical territory under jurisdiction, he is apt to narrow his field of vision accordingly, to recognize boundaries that do not exist, and thus to get one-sidedness or inadequacy of view.

In the development of a particular branch of knowledge concentration of the mind upon the single object follows of necessity, but care must be taken lest the intensity of the effort to reach the heart of the subject shall shut out what is of equal importance. There must be equivocal energy displayed in the study of relationships—in discerning the effect new facts will have upon facts already accumulated, and *vice versa*. The centripetal must ever be opposed by the centrifugal if the golden mean is to be established and progress maintained. Every specialist, therefore, should be a generalist—an authority not only upon the pin point of his habitual observation, but also upon all the avenues leading to it.

In the study of that highest expression of God's handiwork, the human body, with all the forces that actuate it, it behooves the student to recognize the unity of the organism with which he has to deal, and to know at

the outset that a touch anywhere upon or within it is a touch not only of a part, but of the whole; that he has not merely a section to take into account, but an entirety; and that no electric battery can ever show greater sensitiveness than does the life of man from remotest nerve fibril to central ganglion.

Unlike the machinery of a great mill, the parts of which may act co-ordinately, or without special detriment may not act at all, while the great central movement goes on, the human machine is a combination which must act harmoniously in all its parts, inasmuch as there is a genuine community of interest throughout; and no part can be discordant without affecting the tranquillity of the whole.

The thing that characterizes the animal organism, making it dissimilar from every other aggregation of applied forces, is the all-important factor we call life. It is this pervasive force, everywhere resident within the body, that calls to itself the material for building and repair, that keeps the machinery in motion, that stands guard and fights battles when dangers menace, and that establishes through its manifold agencies that vicegerent of highest power recognized as soul, mind, spirit, or vital energy, together with all that these imply.

Life is that force which precedes organization, which sways the forces of nature to its will, and which reigns supreme in the domain of vital technics. Here is an instinct that molds and controls all that pertains to existence, and which must be taken into account in every synthesis and analysis made by the physician. There can be here no such thing as aggregation—no such thing as independent exercise. It matters little how many thousand grains of pabulum a grain of pepsin can digest outside of the body; or what the chemical affinities and reactions may be in the laboratory. The great question is, What will be the result when these are called upon to act in the presence of life.

The bacteriologist with his culture tube, for example,

has made in these last decades vast advancement, thus putting the world under the most lasting obligations; but no one knows so well as he that his problem is hedged by limitations, that results gained uniformly in that laboratory cannot be duplicated at will in the human body, and that germs to grow require a favorable habitat. There must be a proper medium and right conditions, or a nidus cannot be made.

It is common observation that all persons exposed to deadly bacteria do not succumb to their influences; that in all epidemics, such as la grippe, yellow fever, or cholera, the number that contracts the disease is, after all, less than a moiety of those exposed, and that of those even in whom the germ finds lodgment seventy-five per cent. or over recover. Many persons are found who cannot be inoculated, or who take the sepsis to a very slight extent, the malign influences rolling from them like water from a duck's back, leaving them unimpaired.

Why is it that garbage men, sewer men, workmen in fertilizing establishments, in dissecting rooms, and rag factories, and all those in touch with contagion and pollution of every sort, who are breathing or swallowing myriads of death-producing germs every instant of their lives, do not sicken and die to the last man of them? Wherefore is it that millions of mothers who give birth to their offspring in stifling and stinking apartments, and upon beds of polluted rags, worse than a dung heap, do not become extinct through the ravages of septicæmia?

On every hand can be found instances of harmless disregard of all those precautions accounted indispensable in these days of Joseph Lister. Lawson Tait and Knowsley Thornton, holding opposite views on the uses of germicides, go on reducing the death rate in laparotomy in about equal proportions, leaving to their respective adherents the task of reconciling their theories in the light of such diverse practices. Whether the brilliant advancement made in



surgical, gynecological, and obstetric art in the last twenty years is due to antiseptis, severe cleanliness, or improved technique I do not care now to argue. They all hold vital place in the record of progress and will have due award.

The thing that I want to center your minds upon to-day is the fact that there is a greater Richmond in the field than the germicide, or than the thing even that the germicide kills. I want to emphasize the intrinsic meaning of the thing we call life. I would like to make the thought material, that when life is here in all its potency we have a complete wall of defense against all intruders; a fort garrisoned against all foes; a battery invulnerable against all paralysis.

It is coming to be understood that all disease is a sequence of paralysis, a record of incapacity of function, telling of enervated, defenseless, non-resistant organs, and that it is only where the "carcass is" that "the eagles are gathered together," only in decaying or non-vital tissues that bacteria can work their devastations. They are here as the vultures and maggots are on the dead animal—*post hoc*, but not *propter hoc*. They do not create the death, but find it—other processes having been precedent to pave the way. They come as scavengers to clean up an unsanitary city, and under all conditions favorable to them may be expected to fulfill their mission.

Susceptibility to their invasion is only one of the evidences of a lame and crippled vitality. It is one of the proofs that the soldier is not fit for the battle. Some time in the near or remote past his line of defense has been broken down; paralysis of function, in whole or in part, has taken place; some lethargy has stolen over the repellent forces of life, making surrender a legitimate sequence.

In an organism endowed with its full complement of vigor, a *vis a tergo*, strong and valiant to the remotest capillary, all the erectile tissues will be on the alert and fully fortified; a volume of oxygenated blood will be pulsing at

full current through all its channels, clearing every deck for action, holding every tar to his work, and keeping the flag at the mast top.

In other words, life depends upon what is called vascular tone, upon a normal circulation of the blood, upon the accomplishment of a perfect nutrition; and, conversely, disease depends upon vascular atony, upon enfeebled circulation, upon mal-nutrition. This is the very bed rock of all progress in pathology and therapeutics. Out of this nutshell must grow all that is enduring and serviceable in the work of physical salvation. It becomes obligatory upon all workers to gain mastery of these axioms before proceeding farther.

Going down to the capillaries both near and remote, where all the life battles are fought, we must discover the ways of impressing them, study their modes of expression, and all that will conduce to their integrity and most vigorous activity. We must note at the outset their exceeding sensitivity, their dependence upon live blood disk and cell growth, their ready embarrassment and perversion of function; and that no coarse disease expression can ever announce itself upon the broad plain of the body until long after the battle has been waged and lost in these infinitesimal structures.

Whether in the elephant, the tiniest human embryo, or the amœba, life is wholly dependent upon the maturity and prolificacy of the ephemeral cell—upon vigorous cell growth and segmentation—and this in turn upon nutrition. It is all a question of lifeless pabulum and its conversion by the cells into living germinal matter—for it is only in the yolk that cell cleavage takes place. The ceaseless arrival in the capillaries of the blood disk, freighted with all that goes to the nourishment of the cell, and its quick departure on the venous current, bearing with it the dead, the broken, and the useless—this is life, and all the rest follows. Insure a good circulation of the blood, and you

make certain the vigor and full maturity of the body in all its parts.

But how vascular tone is to be engendered, how vaso-motor energy is to be maintained, is the universal problem. This is the trysting ground of all curative effort, and to this accomplishment all theory and practice must apply; whether it be physical culture, dietetics, hot or cold baths, massage, electricity, climate, surgery, or medicines, the common end sought is better energy of blood circulation—the innervation or invigoration of the nerves that creep along all the arteries, and insure healthy vegetation. The question is, How can the reserves be called into action; how can the worn and tired columns at the front be strengthened and rested; how can the magazine and commissary be resupplied?

Before going further with this deliberation I desire to remind you that the nerves that supply the muscular coat of the arteries with power to contract and relax are efferent, motor, or outward bound; that they receive their stimulus from within, instead of without, as is the case with the afferent, sensory, or inward bound nerves, and that the messages sent to and from them are for the most part silent ones; that they are not under the domination of the will, as are the motor nerves generally, but issuing mainly from the ganglia of the great sympathetic, are almost wholly under its control; that they report to and get their orders from the ganglia of the sympathetic rather than the cerebro-spinal; that while they do not have sensory power themselves, or have it to a very feeble extent, they have the ability, in a large degree, to call upon any sensitive nerve in the body to voice their complaints. While apparently the sympathetic is subservient to the cerebro-spinal, the latter is in reality the servant of the former. There is mutual dependence and inter-dependence, but when it comes to the question of rank the highest authority is found with the sympathetic. It is the sympathetic that

rules the vegetative sphere, that presides over all the innermost details of body growth and maintenance, and that has the sole command during all that stage of life precedent to conscious existence, and all that later portion also passed in sleep or unconsciousness from whatever cause. The sympathetic nervous system is the connecting link between the animal and the vegetable worlds, making the line of demarcation between sensitive animal and sensitive plant almost, if not quite, undiscoverable. It takes possession of the individual at his conception—when the spermatozoon makes union with the ovum—and rules with sleepless vigil from that instant till the time when the last spark of vital response is obtainable at the general death. It is the first and last nerve of existence, and serves to make supply and waste—revictualing and consumption—proportionate.

That the ganglia of the sympathetic are the ultimate reservoirs of life—the last to respond to stimuli—is conclusively shown when appealed to in cases of apparent death, and in occasional instances also after complete exporation by the expulsion of the child from the womb, and of urine and fæces from bladder and rectum. The great effectiveness of rectal dilatation in the resuscitation of the stillborn, and of others asphyxiated or drowned, or under the deadly influence of an anæsthetic or narcotic agent, has been conclusively proven in numberless instances of last resort.

The sympathetic was here in what may be termed the paleozoic times of human history, while the cerebro-spinal is its product, and of comparatively late development. While the cerebro-spinal is the outgrowth of the sympathetic, possessing many of its attributes and modes of speech, there are yet heights and depths of vital expression unknown to it.

Integrity of life is maintained through the play and exercise of involuntary forces, which, if normal, go noiselessly and peacefully forward like the deep and still current of a mighty river.

I have dwelt at such length upon these distinctions, because I believe that all true progress in our art is dependent upon the deeper study and better understanding of the ways and means of the great sympathetic; because I am impressed by the thought, growing ever clearer to me, that the ability of the individual to cope with the forces inimical that confront him here is dependent wholly upon the unembarrassed sympathetic nervous system. When I interrogate life processes closely, either in the animal or vegetable world, I find that wherever nature has a fair chance she makes a perfect growth. If she has not been teased, nagged, or irritated through indefinite periods; if her finished product has not been wasted; if her ganglionic or battery power has not been exhausted, but is at hand, like a leyden jar charged with electricity, ready for powerful discharge, you can depend upon it there will be no evidence or incompetency anywhere manifest. Neurasthenia, fatigue, and all candidacy for disease invasion is evidence that the battery is not operative at its best, and that some one or all of the thousands of storage centers in the body have been exhausted in whole or in part of their power.

The measure of life ability and the number of milliamperes of vitality yet possessed are correlative. The reason why Mr. Tait is able to make 139 laparotomies without antiseptics and without a death is found in the fact that he husbands the physical reserve to the utmost. His work is speedy, and there is as little mopping and friction of nerve terminals as possible. When I saw him remove multilocular cysts and diseased appendages in from five to twelve minutes without ever putting a sponge or other mop within the cavity, I understood that it was not a little free blood in the abdomen that he feared, but the unnecessary discharge of vital force through a long and slovenly operation. It was all over so quickly that when the patient recovered from her very short anæsthesia she hardly realized that she had been hurt. Improved

technique consists in nothing so much as the acquisition of masterful ability to do the work required at the least possible cost to the vital remnant.

Coming now to the application and conclusion of this matter, I say that it is the business of every specialist, and every generalist as well, to go behind the returns made by the patient and get back to the initial departure. If he is to do any lasting, worthy service he must not only make the best of the bad condition immediately before him, but, taking the backward trail, he must be able to ascertain why things have reached the present pass. If he would know how to set the switch that shall save the train, he must be able to discern the evidences of mal-nutrition at their very inception. He must be trained not only to report when the storehouse is more or less empty, but how to preserve or restore its contents.

The golden days of our art will not have arrived until its devotees shall have reached that higher plane of service embodied in prevention rather than in cure—in enabling people to reach the highest excellence of physiology rather than in rescuing them with more or less of failure from the death grip of pathology.

It is vastly more to the credit of those in charge of great systems of travel to be found inspecting roadbeds, bridges, and rolling stock, detecting weak places in order to head off disasters, than to be found at the head of a wrecking crew, however well equipped, waiting for expected catastrophe, or endeavoring to make the best of a smash-up.

Dr. L. A. Phillips, Boston, Mass., was introduced, and addressed the congress on the subject, "What Homeopathy Has Done for Gynæcology." Dr. Phillips prefaced his paper by saying :

"You will see as I read my paper that I have dealt with my subject as an abstract one. I have not attempted to state what gynecologists have done for homeopathy, or what homeopathy has

done for gynecologists, but what has been done by the system of homeopathy in the practice of gynecology."

HOMEOPATHY IN GYNECOLOGY. BY L. A. PHILLIPS,  
M. D., BOSTON.

The question, "What has homeopathy done for gynecology?" having been raised and proposed as a theme for one of the essays at this meeting, our honored chairman assigned it to me, and it was accepted with the expectation that an answer to such a question, even if not altogether satisfactory, would be tolerably easy; but the task has proved a much more difficult one than I anticipated. The difficulty lies, not in any doubt of the good work done by homeopathy in this field, but in the absence of positive evidence regarding the administration of any one remedy in any given class of cases, the uncertainty regarding the conditions for which remedies are prescribed in many instances, especially when based wholly upon subjective symptoms, and in the want of knowledge regarding the pathogenesis of the remedies reported as curative. If possessed of that unquestioning and implicit faith which knows or recognizes no conditions or exceptions to the power of homeopathic medication to overcome and cure each and every human ill, regardless of cause or character, it would be very easy to claim that homeopathy had at least furnished the means, if we but make ourselves competent to use it, by which all that gynecology or any other class of diseases presents for relief may be successfully met; and with the exalted power of imagination, which can see the most marvelous effects follow the administration of a drop of water or a grain of sugar, it would not be difficult to demonstrate, to our own satisfaction at least, that by such means more remarkable cures have been and are being effected than by any or all other methods. But I cannot treat the subject from any such standpoint. A general, sweeping claim, without evidence, amounts to

nothing. We want to know if definite and unquestionable results can be shown as the direct effect of homeopathic treatment in women's diseases, whether independent of or associated with other measures.

While we all doubtless believe and feel sure from experience and observation that such results are produced, to define and demonstrate this so that it cannot be gainsaid is a very different matter; and while I do not expect to succeed in doing this to any great extent, I shall hope to prepare the way and perhaps indicate the lines along which, by the testimony of those who may bear witness in the discussion to follow, the demonstration may be made and the fact established. Let us, then, seek to make all our claims rational, and based upon known facts, not upon theories or assumptions. Thus only can we command or reasonably expect a fair and respectful hearing.

In the consideration of such a question as this the term gynecology must be understood to mean broadly the diseases and derangements of the female generative organs, not only in the degrees which bring them under the care of the gynecologist, but in all degrees as presented to the general practitioner or family physician as well; and we must all realize that it is less from the gynecological specialists than from the family physicians that the evidence of the curative power of homeopathic remedies must be expected. While this by some may be deemed a concession or even an admission of the preferred charges that gynecologists are not good homeopaths, I shall deny this, and maintain that it is but a natural and necessary consequence, inasmuch as homeopathy *per se* has to do with nothing but the therapeutics in any case, and it is generally recognized that therapeutic means are most marked and definite in their effects upon functional derangements, and the early manifestations of disease, in all departments of practice; and because the work to be done by specialists is largely that which other physicians by therapeutic methods have not



succeeded in doing, and which generally demand some form of surgical or mechanical treatment.

From the recorded evidence of the skillful prescribers of homeopathic remedies we may reasonably claim that by this means a large proportion of the functional derangements of women are speedily and perfectly corrected without the need of any other form of treatment, and that a very considerable proportion of the diseases, that is, the pathological changes, to which the uterine organs are subject are prevented or cured at the very outset by the same means. Now while this may not be capable of absolute or positive proof, we certainly have strong circumstantial evidence for it, in the fact that women who from childhood have been under the care of homeopathic physicians have far less of this class of diseases than those who have not been so fortunate, and also in the fact that the general practitioners of homeopathy have few cases which they feel compelled to send to the gynecologists as compared with those of the old school who have not the means of relief which our homeopathic remedies afford.

Now while we know that in all spheres and relations of life little credit is given those who guard and protect from impending dangers as compared with that accorded those who rescue the victim from the very teeth of the destroyer, yet it is as true in this instance as in any other that "an ounce of prevention is better than a pound of cure"; and who will not agree that to save a woman from the mental as well as physical suffering which attends the development and course of a uterine or mammary cancer, for instance, is to bestow a far greater blessing than it is possible for even the most skillful surgeon to bring when his services are necessitated? and because: the life which, if saved by the surgeon's skill, is a shattered and blighted one at best, by the other means is enabled to develop *all* its powers, to ripen and produce its fruits free from torture, the impending danger of which was no less real because only in its incipiency.

And so while the surgeon who succeeds in saving the fragments of such lives, even for a few years, wins honor, fame, and wealth, they who have done so much more by protecting and saving lives in their entirety are unrecognized and without reward, often without even the gratitude of the patients, who do not realize what has been done for them.

In this very way homeopathy is doing for its friends and adherents vastly more than they realize or even suspect, and in such a gentle and unpretentious manner that little credit is given and scarcely any evidence recorded. Innumerable cases of this class, that is, of prevention or cure in the embryonic stages of disease, many times unknown to either the patient or the physician, are to be credited to a system of healing which is competent to meet the enemy at any point and in any form ; to fortify against and ward it off, without being compelled to wait its full development or to learn its exact name and nature before active measures for relief can be adopted. This claim will not be allowed, I am well aware, except by those who know and feel the influence and power of this law of cure ; but though we cannot, of course, prove prevention in any individual case, we could, were it practicable, by a comparison of our lists of patrons with a like number differently treated, demonstrate its validity. We cannot wonder nor much blame our old-school brethren for doubting our claim when we remember that they have so generally lost all, or nearly all, faith in the power or virtue of drugs except as opiates to destroy the consciousness of pain, tonics to stimulate nature's efforts, or alteratives to disturb existing functional derangements, hoping that out of the disturbance nature may evolve an improved condition. But to any physician who has had any considerable experience in the homeopathic application of remedies, numberless instances of relief and cure will be recalled to mind by the mere mention of aconite, arsenicum, bryonia, belladonna, cimicifuga, colocynthis, gelsemium, helonias, mercurius, thuya, vibur-

num, and scores of other remedies ; and if you would, one and all, furnish definite and accurate reports of your experiences, we could compel a recognition of the claim that homeopathic remedies in the hands of skilled prescribers can and do cure most cases of functional derangement, and prevent or cure in their incipency a considerable portion of the diseases of women.

Here, then, before reaching the sphere of the gynecologist, we find proofs of homeopathy in gynecology of which we may well feel proud. But it does not end here, the opinion of some of our critical brethren to the contrary notwithstanding. I think I am safe in claiming that in the practice of homeopathic gynecologists fully one-half the cases which under old-school treatment would remain uncured or be subjected to surgical operation are cured by homeopathic treatment. Not every case is thus curable, and many demand surgical treatment. But we do, by combining homeopathic medication with the needed mechanical measures, cure many pathological conditions ; such, for example, as metritis and endometritis, pelvic peritonitis, ovaritis, uterine dislocations, fibroid tumors, salpingitis, etc. And we have some well-authenticated cases in which ovarian cysts have disappeared during the continued application of the indicated remedy ; and not only this, but very many who have endured for a longer or shorter season the attempts of the old-school specialists to cure, come to us and find the relief they had previously failed to receive ; and certainly not because we are better mechanics, but because we have the homeopathic remedies to aid us ; and this is equally true in cases which require surgical treatment. While the knife removes the cause of difficulty, the remedies remove many serious effects, and afford relief to the suffering nerves unknown to any other method of treatment. And not only this, but the healing of wounds and convalescence are more rapid and perfect when thus treated than when opiates and poisonous drugs and dressings are used.

Inasmuch as it is becoming ever more evident that the sufferings of women which gynecologists are called upon to relieve are very largely neurasthenic or of nervous origin, and that even the removal of pathological conditions, especially by surgical means, does not always give complete, and oftentimes little or no relief, we find new and increasing reasons for endeavoring to find homeopathic remedies to meet these conditions, and I believe it is because our remedies, rightly applied, act upon and through the nervous system chiefly that their effects, even when intended to act upon a pathological condition or a certain organ, have been more potent than the cruder methods, which shock or numb rather than regulate the nervous forces.

I feel that it would be hardly just on my part not to state that the specialists (or perhaps I need speak only for myself) do not adhere strictly or exclusively to highly attenuated medicaments nor to the more common method of administration *per oris*. Experience has taught me that, in treating the diseases and derangements of the pelvic organs, I can get much more decided and speedy effects by applying glyceroles, triturations, cerates, or in some cases crude substances to the mucous or denuded surfaces, the medication being selected to correspond with the symptoms, just as in any other class of cases, or for the ordinary manner of administration. And we can maintain with the highest authority, Hahnemann himself, that such medication is no less homeopathic than giving the same remedies for similar conditions by the mouth.

While in our surgical cases by the use of calendula, hypericum, hamamelis, arnica, etc., rapid healing is promoted, suffering is greatly lessened, and with the further aid of other indicated remedies before and after operations opiates are rendered unnecessary in nearly all cases, and convalescence thus promoted and hastened; and while in our office practice we are curing active congestion of the uterine

organs, attended by the characteristic symptoms of belladonna, by a local application of glyceroles of that drug, the passive or venous congestions with hamamelis, syphilitic ulcers with mercurius cor., indurations or hyperplasia with iodine, etc., etc., and doing it much more surely and speedily than it can be done otherwise, who shall deny that homeopathic gynecologists are as truly and effectively demonstrating the power of homeopathy as they who prescribe these same remedies in attenuated form and by the mouth for like conditions?

Feeling as we do that we have a right to claim much for homeopathy in gynecology, it must still be admitted that much more might and should be accomplished in this field, and I am granted the privilege of indicating some of the means by which more definite and more convincing results may in future be obtained.

First of all, we must have more thorough provings of our remedies by women, and with competent observation of their effects upon the pelvic organs. As it is, we have very few pathogenetic symptoms to guide us in selecting remedies, and hence empiricism plays too large a part in our use of remedies; and while we may *claim* that the remedy which effects a cure is therefore homeopathic, unless we have a proving to correspond to our case we cannot establish our claim before an impartial jury. We have at present more than ever before women who, as members of the profession, must realize the importance of this work, and some measures should be adopted to establish and endow, if necessary, a school of proving to which they might be induced to lend their aid, where thorough work and reliable observations could be secured and recorded. When this has been done it will enable the general practitioner to cure a still larger proportion of incipient diseases without the aid of the gynecologist, and at the same time will give to the specialist greatly increased means of successfully treating

the more serious diseases of women, and rendering surgical treatment a much less frequent necessity.

Second, there should be greater accuracy in the observation and reporting of cases in order to make clinical experience a more reliable guide. Accurate diagnosis by physical examination is essential in every case if we are to pretend to state the pathological condition. Yet so many instances are on record in which cures of definite conditions, as of endometritis, or even tumors, for instance, are claimed, in which it is found upon investigation that no examination was made, and hence no knowledge possessed of the pathological changes present, that it not only renders these reports worthless as evidence, but it throws suspicion upon all such claims. And again, cases in which no records are kept, and which may have occurred some considerable time previous to being reported, are so likely to be smoothed over and rounded out with the lapse of time that they take on a form and appear to have a significance which could not be depended upon, and which destroy their value as evidence. It is important, then, that we keep written records of the cases we report, and that we have a definite knowledge of the objective as well as the subjective symptoms in each case. Who can doubt that with these conditions, and with the greater knowledge of the homeopathic remedies which thorough provings by educated women would afford, a showing could be made of homeopathy in gynecology which would surprise even its most ardent friends? This we may hope for at some future World's Congress, but at this time I can only ask, in closing, that the army of family physicians here present substantiate my claim that homeopathy in their hands cures a large proportion of women's diseases, and renders its adherents much less subject to such ills than those otherwise treated; and by the gynecologists I hope to be re-enforced in my claim that we have in homeopathy a means of curing many conditions which baffle all other re-

sources, and that in aid of surgery it has proved itself a reliable and powerful ally.

The discussion on Dr. Phillips' paper was as follows :

DR. A. C. COWPERTHWAIT. — As I heard this most excellent paper read, the thought came to me, What if it were possible to-day to have a panorama presented to us of those silent yet actual witnesses to the benefit that homeopathy has been to gynecology? We ourselves would be astounded at that which has been accomplished within even our own knowledge; and yet, at the same time, another thought struck me in a little different direction, and that was that in all that homeopathy has done for gynecology it has not done one-half or one-tenth of what it would have been glad to do, if it had only been given half a chance.

We must admit that when a man becomes a specialist his tendency, as the first speaker of the afternoon said, is to become an intense specialist, and so we find that while not all, a great many gynecologists become so wedded to their instruments and their mechanical measures that they forget the power of the armamentarium that they have behind them.

I am glad to hear a paper like this read here to-day, even if our brother does prescribe his remedies in crude doses and apply them locally. I have always been one of the number that believe we had to do that. I remember I had to get out of the hotel at Milwaukee, where I was one of the charter members of the International, because I would not subscribe to the doctrine of never using local applications. But at the same time we should not for one moment forget that there is something in the powerful action of potency, or, if you prefer to say, attenuated drugs, that reaches beyond and deeper, and does more than the mere local applications of drugs, no matter how beneficial that may be, to certain local conditions that may exist.

I remember reading some years ago a very beautiful

account written by Dr. Mercy B. Jackson of Boston, now deceased, as she was telling her own experience of the effects of sepia upon her own person when suffering from uterine displacements. She said that she felt that she could feel that medicine by its mighty power raising that uterus into position, and it did it, and it stayed there; and there are plenty of homeopathic physicians who have had similar experiences in their own practice. I want to ask of you to-day candidly, how many gynecologists do you suppose carry sepia around with them as one of their chief anchors in the treatment of diseases of women? I never have known one yet. I don't care how you use it, we have in this one remedy, sepia, one of the grandest remedies of homeopathy, and yet one of its most neglected ones.

Now to come to the point made in this paper which I consider of far more benefit to us here to-day, as being of some assistance in helping us to develop something in this line than any other part of this all-valuable paper. That is the suggestion that has been made to the ladies. I have often wondered why the lady gynecologists did not band themselves together for the good of their common sex, why it was that, knowing as they do know the tortures that are being continually perpetrated upon their sex by gynecologists, they do not put their heads together and try to see how to modify these measures; yet there is very little tendency in that direction.

I was told by a gentleman, and I hope if he is present he will pardon me, that while he had nothing to say about male gynecologists, if he wanted one that was real harsh, and would stretch and tear and bend, just give him a woman gynecologist; that they did not seem to have any feeling for their sex in these matters.

Now that may not be altogether so, but think for a moment if there is not some truth in it, and if it is not a proper thing for the ladies in the homeopathic profession to follow the suggestion laid down in this paper, and that



is to go right to work and see what more there is in homeopathy that has not been applied in its proper methods. Organize provers' clubs, which you alone can do, conduct them according to your own wise methods, establish the value of our remedies in a way that none but yourselves can possibly do, and then show to the world by the practical application of these remedies what homeopathy can do for gynecology.

I believe, as I am one of those who have always very strongly favored ladies, that this suggestion will be taken as coming from a friend.

And so we find that homeopathy has done something for gynecology. We cannot give a long row of statistics here to-day. We might give many. The statistics are hidden in the quiet recesses of many hearts, and even some of those hearts that have been most benefited know it the least ; and so if we will but take to our bosoms the truths that have been given us to-day by Dr. Phillips, and have less of our mechanical and surgical measures and more of our therapeutics, combining our materia medica more completely and thoroughly with our mechanical measures, in ten years from now there can be a great deal more said as to what homeopathy has done for gynecology than can possibly be said to-day.

WEDNESDAY, MAY 31, 1893.

DR. AVERY MCCracken.—I would like to make a cry against the over-local treatment, and to do that clearly and concisely and in five minutes I will give you a case. A young girl of twenty in the fall of 1873 became very ill suddenly. She was taken to old Dr. Foster of Clifton Springs Sanitarium. It was pronounced a nervous and mental trouble, and Dr. Prince, whom some of you may know, was her physician. She was there six months. In the summer of 1874 at her own request she went to Dr. John P. Gray of Utica, and between the summer of 1874 and the fall of

1878 she spent three years and one month in the Utica Insane Asylum under the care of John P. Gray and his colleague Dr. Andrews, who has since become superintendent of the Buffalo Insane Asylum. The first time she was there was for twelve months, the second time twenty months, and the third time six months. She realized as well as John P. Gray did that he considered her case hopeless, and he let her go at the end of six months, thinking that she would return soon. While she was in a comparatively good state of health she might as well be at home with her widowed mother. In the spring of 1878 she was taken as a last resort to Dr. R— of Albany, a homeopathic physician, who insisted upon a local examination. He assured all her friends that there was there trouble enough to have caused all the nervous and mental disturbance. He gave her local treatments steadily six to eight months at a time, from the year 1878 until fate brought her to Chicago in 1883. I do not mean that he was all the time giving her local treatments, but that he would treat her for a few months, dismiss her as well, and a few months afterward the nervous and mental disturbance came back again, and she would return to her physician.

In 1883 she came to R. Ludlam of Chicago, and after carefully studying the case and carefully affiliating the remedy, he prescribed for her. He did not examine her. He gave her no local treatment, and she only took twelve of his prescriptions. Ten years have since elapsed without any recurrence of her nervous and mental trouble.

DR. JULIA ROSS LOWE.—I wish to call attention to two remarks—one in the paper and one in the discussion—which have attracted my attention. Speaking of sepia restoring a dislocated uterus, I believe remedies effect a great deal, but I think that is asking too much. I do not believe that sepia or any other remedy will restore a dislocated uterus any more than it will a dislocated arm.

One of the speakers said that of all the heroic treatment

he had ever seen, the worst came from women gynecologists. I am a practitioner of many years' standing. I have had in my office many women the victims of malpractice, and only one of some twenty-five that I can recall came from the neglect of a woman physician. I have seen women sewn and torn and maltreated by men, but only one can I recollect that was maltreated by a woman, and she sent the patient home from her office some miles with a sponge tent. This, I think, was neglect.

Now this is not a criticism upon men practitioners, and I do not wish it understood in that sense. I only wish to refute from my own ten years' practice the statement that was made.

DR. WOOD, Ann Arbor, Mich.—A case apropos to the one that was recorded regarding the effects of general treatment after local treatment had failed. Some six months ago I was called in consultation with one of the best prescribers in our State to see a young lady who was suffering from melancholia, so much so that the idea of removing her to an asylum was seriously entertained. The various prescriptions had been made without avail. The patient kept getting worse and worse. Her melancholia was of a suicidal type, and her condition was most deplorable. An examination revealed a bad retroflexion of the uterus, which was overcome by a pessary. Some two weeks ago the patient came into my office and greeted me. I hardly knew her, and she said, "Doctor, you came to see me some six months ago when they were talking about taking me to an insane asylum. I want to tell you how perfectly well and perfectly happy I have been since you fitted that pessary."

This was a case which could not possibly have been reached by internal medication. At least internal medication had been given a most thorough trial. It was a case eminently proper for local treatment, and I think as gynecologists we have got to discriminate in those cases. I

think we should ordinarily try our internal medication. I believe in the power and efficacy of the homeopathic remedies for these conditions under suitable circumstances. But while we are doing this there is a danger or an evil which is more prevalent in the homeopathic school than in the old school, because of the belief in the efficacy of the homeopathic remedies, and it is that of neglecting local examination, and overlooking and neglecting the malignant conditions.

We expect to have this afternoon a paper upon the subject of "Vaginal Hysterectomy." That very important subject and very important operation has reached a point where, if we get our cases in time, we can save a goodly per cent. of them; but we have got to have them in time, and there is danger, I believe, if we rely too absolutely upon our internal medication, of neglecting our examinations until malignancy comes, particularly in that class of patients approaching the so-called cancerous age, and I know from my own personal experience that the general practitioner relies too absolutely upon internal medication for controlling symptoms the cause of which he should seek by local examination.

Now I say that I believe in the efficacy of internal medication, but I was glad to hear someone proclaim the absurdity of trying to set a uterus by the internal administration of *sepia*. It is such absurdities as this that make homeopathy ridiculous in the eyes of the public. Subjective phenomena are liable to be mistaken.

DR. R. LUDLAM.—I want to express my thorough appreciation of the paper that was presented by Dr. Phillips, which paper we have been discussing. I like such a paper as this. We do not have enough of them. It is careful, practical, and discriminating. It is not too enthusiastic. It is sensible, and it will be useful. I like the suggestion immensely as to the duty of the women in this Institute. The crowning argument for the admission of women to the

floor of our national society after Dr. Mercy B. Jackson, Dr. Swazey, and a lot of other great physicians who have gone to their rest, had knocked at the door for several years without getting in, was made by Dr. Carroll Dunham, and that argument was in exact line with the recommendation or suggestion of Dr. Phillips.

We want the women in the Institute. We need them as provers. They can make provings that none of the rest of us can make or can even superintend. That argument brought them to the Institute, and it was my pleasure to put the question when they were admitted, and I shall be proud of it if I live a hundred years. I am glad this subject has been discussed, because it is shown to-day that this question, like every other, has two sides, and that people may be very honest in their views on either side, that we grow and learn by contact, by coming together and comparing our experiences.

I believe most heartily in the efficacy of homeopathic remedies for many diseases of women. I am perfectly satisfied that the scope of the remedies will grow, and the utility increase as time goes on, and we will learn how to apply them; and that in just such ratio the coarser, cruder, and apparently more cruel surgical means that we have to resort to now will be less and less. Upon the other hand, I believe that surgical measures in the right hands, guided by the right brains, are useful, and will always be useful in this specialty.

I cannot hear any reflection upon gynecologists as a class—I mean the better ones—without a little bit of resentment. What would we have known of gynecology diagnoses without the gynecologists, and what would our testimony be good for as to the efficacy of homeopathic remedies if we were not competent to make careful diagnoses? Therefore I say we need the gynecologists. We cannot be good theoretical gynecologists until we are good in the way of diagnoses.

There are two sides to this question, and when we are interested in one we are apt to forget the other. I could not help recalling the story told by Henry Ward Beecher about the old darky who fished all day and toward the end of the day caught a catfish. He threw it back into the water and said, "When I goes catting I goes catting, but to-day I'se piking."

I think we must be careful not to insist too radically on the different classes of symptoms, I mean to say upon our experience as being all one way or the other. Let us be well balanced, well poised, and then our experience and, what is more, our advice will be worth something.

DR. HAWKES of London.—I believe firmly and sincerely in our medicine, and I try as far as possible to put off an operation. I have now several cases that come to my clinic at home where the ovaries and what not have been condemned by operation where I have been able to give medicines and get a cure. I have had the happiness of talking to a good man, a very excellent friend of mine of the other school of medicine, who declared that whereas an operation was in his opinion necessary and called for on a previous occasion, now no such necessity existed.

I think that such medicines as palladium and apis, with stannum to come after sepia when the sepia is not quite efficacious, will do a great deal with these cases, and that operations will become fewer and fewer as we understand the possibilities of our materia medica better.

I am glad to be told that so many ladies are practicing medicine, and I am sure the grandest possible good will come from their combination with us of the sterner sex to all.

DR. C. B. HIGBEE of St. Paul, Minn.—I can indorse everything said in the paper of Dr. Phillips. There is one remedy which I believe to be homeopathic in its action, which I have found very efficacious in treating this class of diseases, which has not been mentioned. I believe the

action of electricity in gynecological cases is homeopathic. I have had quite a large experience for several years in the use of electricity in these cases and with excellent effect.

It is difficult to say at the present time with our limited, I think I will say, proving of electricity, just how it acts, but I believe it is through the nervous system, and that it re-establishes the capillary circulation which is at the base of most of these diseases. I know from the experience that I have had with it that it clears up many of those cases much more rapidly than I could possibly do with any drug that I have ever administered. Perhaps I did not select the proper drug or give it in a potency high enough, but I did the best I could.

Before you give up your cases, try thoroughly electricity.

DR. FLORA A. BREWSTER of Baltimore, Md.—The doctor who has preceded me has stolen a part of my thunder. I shall have to begin where he left off. I believe the chief cause of the troubles which we gynecologists treat in our office is uterine œdema. I believe that all the misplacements that we are called upon to deal with, if we could get the patient in time and could restore the muscular tone we would prevent the misplacements.

Unfortunately we never get them under our care until the person is crippled, and I believe it is an absurdity to attempt, when all the blood vessels are out of place, when the blood easily passes into the organ, and it is almost impossible for it to escape, when waste matter is left in it and the organ is growing heavier, to restore that organ by medicines alone. Why should not we as homeopaths use the very best means in our power to gain all the knowledge we can in restoring the human body? I believe if we would do that very much of the opprobrium that is heaped upon the head of the poor homeopathist might be averted, and I believe that one of the most effective means we have in restoring uterine tone is electricity.

Doctors have said to me, "Oh, the worst cases I have ever seen have been women that have been to an electrician." It is because they did not know how to use the battery. How many doctors are there that know what a current of tension means, or the difference between a current run through a long fine wire and one run through a coarse heavy wire? You will get exactly opposite effects. One kind will decrease the inflammation and the other will increase it.

I know positively that a uterus can be taken that is retroverted and imbedded in a mass of adhesion, and a current can be passed through it in perfect safety, and these adhesions can be broken up, and that uterus lifted to its normal position. Not in one treatment, or three, or five. It needs a person of good judgment and large experience.

The chairman called upon Dr. Phillips to close the discussion.

DR. PHILLIPS said: Nothing has been developed which makes me wish to express a different opinion or add to what I have said. The use of local remedies and internal medication goes without saying. The same indications which lead to the local use of belladonna would lead to the internal administration of the same drug, and the internal remedy in my experience is almost always identical with the local.

In regard to sepia I would like Dr. Cowperthwaite to know that there is one gynecologist in the United States that carries sepia in his case, for I never go without it. I use it not to replace a displaced uterus which has been impacted, but to strengthen the ligaments after it has been mechanically replaced.

DR. J. M. LEE of Rochester.—It was stated by one of the speakers that electricity in some way or other was sufficient to break up or to cure all cases of so-called pelvic cellulitis, and that if such diseases were not cured by the



application of electricity it was because the operator did not understand the use of the agent. There are cases of adhesions that cannot be broken up with the fingers, and it is absurd for anybody to get up before an audience like this and state that electricity can cure all those cases. I want to protest against any such talk as that.

DR. HIGBEE.—I haven't heard anyone say that electricity could break up those adhesions. I do not believe they can be so broken up. It will stop their growth.

SOME OF THE CLINICAL ASPECTS OF SEPTIC INVASION. BY  
EDWARD T. BLAKE, M. D., LONDON, ENGLAND.

I do not doubt that you will all be prepared to admit that the most elevating conception of the highest and noblest of all professions is that which views it as a means of preventing disease.

Because this is so it is difficult to overestimate the importance of establishing ætiology on a sound and scientific basis. So swift have been the recent strides toward this excellent consummation of our desires that it is quite impossible for a single intelligence to keep pace with them.

Though it is undoubtedly true that we can, with some measure of success, encounter certain manifestations of disease knowing nothing of their real causation, it is equally true that without ætiology we cannot do our best by our client to protect him from future visitations of the same malady.

We say most truly *felix qui potuit cognoscere causas*, for not only is some knowledge of ætiology needed for the prevention of disease, but some special knowledge of predisponents and excitants must deeply tinge our general selection of measures designed to afford relief to those intrusted to our care.

It is plain that there could be no state medicine without scientific ætiology.

Equally there can be no fixed basis of nomenclature.

For example, have we not seen that the selection of names based on physical characteristics alone may lead, as in the absurd artificial classifications of skin diseases, to the most ridiculous results? Arranging smallpox with ecthyma antimoniale, and erythema with scarlet fever.

The only hope of a definite scientific taxonomy is to have the generic terms founded on physical or physiologic characteristics, and the specific distinctions based on causation. Examples are "chondritis arsenicalis," "synovitis traumatica," and "pharyngitis septica."

It will be, then, from the ætiological side that I shall, with your permission, approach this large and important subject.

#### *Acute Sepsis.*

Concerning acute sepsis, I shall have very little to say. In women its most typical, and certainly its most appalling, form is childbed fever, a disease which has grown to be more rare since Listerism has come into vogue, a disease destined, let us hope, ere long to disappear altogether from civilized communities.

I was assured by Professor Victor Horsley, when he acted as registrar of the Maternity Department of the University College Hospital, London, England, that the substitution of vaseline for lard on the hands of students, who went from dressing surgical injuries to the lying-in bedside, effected a perceptible diminution in the number of cases of puerperal septicæmia.

Inasmuch as this disease is easily prevented and is nearly incurable, all our energies should be devoted to rendering the parturient woman, and all her surroundings, as aseptic as possible.

A few words as to the chief indications for managing a case.

1. See that the uterine cavity is absolutely clear. It is better to remove a part of the wall of the womb than to leave behind the very smallest portion of chorion

after an abortion, or of placental membrane after miscarriage or labor at term.

2. Keep the cavity constantly irrigated with some warm solution or harmless antiseptic, such as boric acid, taking care that the egress tube of the double canula employed be far larger in internal sectional area than the ingress tube.

3. Keep the cervix patulous, and if possible arrange that the patient be in an appropriate posture for easy drainage.

4. Protect or remove needless absorbent surfaces.

#### *Subacute and Chronic Sepsis.*

We see examples of rather less acute septic intoxication in surgical erysipelas, established gonorrhea, coprostatic urticaria resembling the form which arises from decomposing food, extensive cutaneous burn, diphtheria, pyometra, pyocolpos, otitis suppurans and disseminated abscess, infective osteo-myelitis, and in the so-called "zymotic" fevers.

The infinite varieties of toxine produced during these invasions of anabolic and katabolic tissue changes, and by the decomposition of pus, of mucus, and of other liquid products of the body, exhibit, when we consider their elaborate differentiations, a curious unanimity both in the method of attack and in the selection of sites of action.

Thus they all prefer to act on the endothelium and the epithelium of children. They prefer the nervous system of women and the joints of men. That is, of course, only another way of saying that the skin and mucosa of the young, the cerebro-spinal system of women, and the joints in men, are either their weakest points respectively, or else they are the most active in their efforts to rid themselves of poisonous material.

To avoid repetition I will consider the distinctive characteristics of subacute septic invasion with those of the chronic form, for in the latter the former insensibly merge.

*Skin.*

Just as in acute sepsis the skin affection is usually erythematous, so in the more chronic forms the cutaneous manifestation is nearly always some variety of nettle rash. In the ill fed and the aged it may be replaced by petechial or purpuric affections.

*Urticaria septica* is sometimes seen in the course of chronic gonorrhea, when it may be complicated with certain drug rashes—such as the *copaiba dermatitis*, which occasionally presents features resembling nettle rash.

In a pamphlet entitled “Sepsis and Saturnism,” in which I have shown the curious resemblance which exists between the *modus operandi* of septic matter and of the soluble salts of lead, I have described a form of *acne rosacea* of the face arising from carious teeth. This may be compared with the septic rash (*roseola enterica*) seen on the abdomen of the typhoid patient.

Also at page 15 of my work on septic intoxication I have given an example of multiple symmetrical petechiæ occurring on the cheeks of an old lady, evidently arising from suppurating fangs, for they disappeared after the removal of the carious roots.

Purpura has been produced by direct experimentation of poisoning by ptomaines, and there is little doubt that the diseases roughly grouped together as *hemorrhagica purpura* are some of them septic in origin.

I have elsewhere shown that nearly all the toxic eruptions may attack any portion of the epithelium. But there are favored sites.

Internally the throat is, for many reasons, a preferred locality, as we see in diphtheria, scarlet fever, and some of the other zymotics.

Outside the body the forearm is the most common site of septic rash. The musculo-spiral distribution is the area most frequently affected.

The musculo-spiral has a few peculiarities which we shall be repaid for noting. Developmentally it is a very old nerve, being found in the earliest types of anterior limbed polite nerve, and it never encroaches on its neighbors. Unlike the ulnar, which often reaches as far into the musculo-spiral area as the root of the index finger, the musculo-spiral shows no retaliatory spirit. It is a nerve of vicissitudes. Besides being perpetually and abruptly stretched during pronation, it receives most of the blows which reach the forearm. Being a silhouette or outline nerve, it is much exposed to the changes of external temperature.

Many toxic eruptions appear first either on its superficial area or on that of the fifth cranial pair. An example is iododerma, which is usually best seen on the forearm and the face. It follows occasionally the dressing of the endometrium with iodized phenol.

The distribution of the musculo-spiral is the point to examine for the earliest manifestations of the peculiar eruption characteristic of uræmia. These are the so-called maculæ uræmicæ, first described with anything approaching accuracy by LeCronier Lancaster, of Swansea, England. Here are also often first seen the xanthoma of osteo-arthritis, so often septic in origin.

These pigment spots on the forearm, yellow under the clothes, and sepia-like where they are exposed, were first alluded to by me in the *British Journal of Homeopathy* in 1881. The various forms of dyschromia associated with rheumatism were afterward, in 1885, most carefully and elaborately described by Dr. Kent Spender of Bath, under the name of multiple xanthoma.

Next in order of frequency is the trigeminus or nerve of sensation of the face. Then come the cervico-spiral nerves.

It is full of interest to note that the area of distribution of toxic skin staining corresponds with the area of the distribution of osteo-arthritis. But I have already ex-

plained elsewhere why this should be so.\* The toxins which induce abnormal pigmentation also have the property of causing rheumatic gout.

The xanthoma of septic goiter, of glycosuria septica, and of purulent infection of the adnexæ (Addison's bronzing) are familiar examples of the chromatic changes induced by chronic sapræmia.

A form of ptomaine pigmentation has been recorded by Dr. John MacPherson,† of Stirling Asylum, at Larbert, N. B., in an article entitled "Intestinal Disinfection," where he found that by destroying the toxins of the primæ viæ in lunatics by means of naphthalin he could relieve insomnia and remove the morbid pigmentation of the skin which occurs in cases of melancholia.

The relief given by MacPherson to his sleepless maniacs, by rendering their intestinal canal aseptic, brings us naturally to the consideration of the influence of sepsis on

### *Sleep.*

It must not be taken that the absorption of septic matter is always an evil. We see certain persons who are always absorbing septic matter from dirty teeth or from neglected genito-urinary catarrh, and who yet enjoy most vigorous health. This apparent contradiction is explained in the following way:

1. Degraded tissue material, in minute doses, forms one of the normal stimuli of the heart; witness, for example, the exhilaration which follows exercise.
2. Larger doses overstimulate the heart—athletic sleeplessness.
3. Overdoses cause profound sopor—toxic coma of extreme fatigue, of uræmia, and of puerperal septicæmia.

Sleep is also secondarily disturbed by the distressing

\* See pp. 19 *et seq.* of "Septic Intoxication," published by F. A. Davis & Co., Philadelphia.

† *Journal of Mental Science*, January, 1893, London, England.

itching of the dermatitis septica which we call "nettle rash." Apis and sulphur relieve this. I have sometimes stopped it completely by giving a very hot bath, followed by painting over the affected part after patting, not rubbing, the patient dry, the following solution:

R	Cocain mur.....	gr. ij
	Chloral hydrat.....	℥j
	Glycerini.....	℥j

Camphor, instead of cocaine, and sometimes sal amoniac will give relief.

The smarting may be stopped by

R	Ichthyol.....	gr. xx
	Collodion flexile.....	℥j

applied pure three times a day.

### *The Skin.*

Disregarding the rarer and more recondite results of sapræmia, we will glance quickly at the ordinary superficial phenomena of passive poisoning by purulent products in a female patient.

As the subject of chronic septic absorption enters the room, we are struck by her deathlike<sup>2</sup> pallor. There are exceptions—some women become sallow, some bronzed, so as to resemble a case of Addison's disease \* or one of the other disorders connected usually with xanthelasma; others present discrete spots of melanosis, the favorite sites being, as we have seen, the forearm and the face.

I have already noted multiple symmetrical petechiæ on the cheeks of the aged, which have disappeared on removing rotten teeth.

Purpura has been caused experimentally by injecting toxins into the circulation. Scorbutic petechiæ are possibly of this nature. There are grounds too for looking upon general hemorrhæa purpura as septic in origin.

\* Addison's, Drummond's, and Nothnagel's diseases are all probably septic.

Acne rosacea will follow pyorrhea alveolaris, and vaginal xanthorrhoea is often associated with pustules on the chin (acne menti).

The rose spots on the abdomen of an enteric patient are probably of the same nature. It will be remembered that they do not all appear during the first week of the disease, in other words, till there is time for the establishment of necrosis in the neighborhood of Peyer's patches.

Raimondi found the same atrophy and degeneration of the bone marrow in saturnine cases as appears to occur from septic causes in the course of male urethritis.

A profound and inexplicable hydræmia \* should always arouse our suspicions of septic intoxication or of lead poisoning.

In old cases of septic invasion the corner of the mouth is prone to show a fissure. This cracking of the lip commissure appears preferentially on the side of habitual decubitus. It is not quite so insignificant a matter as might at first blush be thought, for the act of opening the mouth becomes so painful that the patient would cease to eat unless the corner were protected. A strip of adhesive plaster serves sufficiently well for this purpose. I have in these cases tested the saliva both before and after food. I have found it acid even when escaping from the salivary duct antecedent to its admixture with the mucus of the mouth. It is possible that the mere subalkalinity of the blood which passes through the cortex † may induce various neuro-psychotic phenomena, as ill temper, headache, despondency, chorea, or epilepsy. We know that the last of these is influenced by the various salts of sodium and potassium. This property, possessed by the alkalies, of modifying some nerve storms, may depend on mere chemical action rather than on any specific relation to the pathological condition.

\* Compare with recent observations by Dr. Archibald Garrod on the blood changes of rheumatism.

† Compare observations of Hughlings Jackson.



The advent of the epileptiform convulsion is aided doubtless by the contracted state of the cerebral arterioles.

We have been accustomed to view puerperal convulsions as in part sapræmic, but chronic idiopathic epilepsy, not unusual as a result of lead poisoning, is not ordinarily recognized as a septic symptom. Professor Wood of Michigan University has narrated the particulars of a case, and I have myself placed two on record.\* One showed petit mal associated with depravity, the other genuine epilepsy.

Recurrent nettle rash, as well as lichen urticatus, especially the *post-partum* form, should lead us to search for septic intoxication and to take immediate steps for its remedy.

Hyperidrosis of the hands, the feet, and the axillæ is by no means uncommon in sepsis. Compare this with the localized sweats observed by D. Kent Spender in the course of osteo-arthritis.

Drs. Ord and Spender have also pointed out various sensory perversions as occurring in the course of rheumatic gout, itself often septic in origin. Such are lightning pains of the lower extremity, a sense of tearing up of the skin, spots of anæsthesia and of hyperæsthesia. These are common in septic cases. They serve to show that rheumatic gout is not merely a disease of the joints.† Rheumatic tremors point in the same direction.

The temperature of the extremities rises during the chondritic stage of rheumatic gout. *This increase in surface warmth is often diffused in the neighborhood of an articulation; it is not confined to the point of incidence of the arthropathy.* Afterward the limbs are prone to be purple and chilled. The arterial tension‡ is heightened at first by

\* "Septic Intoxication," pp. 52, 53. F. A. Davis & Co., Philadelphia, 1892.

† Compare with Charcot's disease and with tabes.

‡ On September 6 the right radical of a gentleman, aged seventy-two, recorded nine ounces while sitting down. Late in September he contracted a sharp attack of urethritis, and the tension rose to ten ounces. A man of thirty-six, with acute urethritis, showed ten and eight ounces in right and left radicals.

septine, and is followed by increased vigor of ventricular contraction.

But there is a later stage in septic invasion, where the systole is defective even to the extent of developing anginous symptoms, as I have more than once witnessed.

Mental solicitude and gloom are nearly always present in septic patients.

### *The Digestive Tract.*

The septic tongue is peculiar, the type of acute sepsis being the enteric tongue. In chronic cases it may be coated, sometimes preternaturally clean, with raised irritable papillæ, sometimes very thin at the edge, often œdematous, showing the marks of the teeth.

In acute sepsis, as after diphtheria, we may have pharyngeal paralysis; in acute saturnism we get spasm of the pharyngeal constrictors; both are prone to be followed at a later stage by inco-ordination of the muscles concerned in swallowing.

Loss of appetite, resulting in emaciation, is common to both these poisonings.

I have seen three cases of recurrent gastralgia, of six weeks', three years', and ten years' duration respectively, disappear on removing pus despot.

We have seen that sepsin appears to possess the property of causing pain, called "gastralgia," in the terminal twigs of the anterior or ventral branches of the fourth, fifth, and sixth dorsal nerves.

Drs. Pearson Irvine and Wm. Pasteur have shown that

Out of 36 patients suffering from various slight disorders, 32 had differing radicals. In 26 the right was the more vigorous. A greater disproportion was observed in women, whose tension runs much higher than that of men. Six persons, including both sexes, had the left higher. Four only were symmetrical. Sixteen ounces right and twelve left was recorded in septic goiter, with chondritis, eczema, and severe varicosis, associated with suppurating endometritis, in a woman of fifty-one, wife of a seafaring man. The observations were taken by means of Dr. Rayner Batten's manometer.

death from diphtheria, especially in boys, may come from a paralyzed phrenic. This is confirmed by Suckling of Birmingham. It is interesting as showing another point of contact between septic toxæmia and lead poisoning, for phrenic palsy occasionally closes the scene in acute lead poisoning.

One of the last results of old-established septic intoxication is hepatic disease of lardaceous type. In these cases the liver ceases to seize upon and change the various degenerative gastro-intestinal products, which now enter the general circulation and prove most pernicious, especially to the nerve centers.

### *The Eye.*

The eye symptoms of sepsin present a superficial resemblance to those of lead, but there is a deep-seated difference.

The septic affections of the oculo-motor apparatus generally are familiar to us after diphtheria.

There are good grounds for suspecting the existence of a septic glaucoma.

Dr. John Brown of Bacup, Lancashire, England, in his graduation thesis, dated 1889, recorded a case of acute glaucoma which, though the eye symptoms came on in the course of plumbism, may be viewed as saturnine. For it occurred in a woman fourteen days after her confinement, so it probably had septic elements in it.

Mr. Lennox Browne, in his work on diseases of the upper respiratory tract, gives details of a very remarkable case of septic glaucoma.

Mr. Browne quotes also some American observations on the same subject.

Sepsin is very prone to produce supraorbital pain, sometimes symmetrical, more frequently sinistral, rarely on the right side. The lead headache when lateral is on the right side. The actual recorded relation is 7 to 3. Asthenopia is common to both lead and sepsin. The defective vision

of sepsin is usually an accommodation error of temporary character; but persistent blindness from optic atrophy has more than once followed poisoning by lead. It is curious that sepsin appears to pick out the nervous and muscular structures and choroidal coat. Lead first attacks the vessels (hypertrophic peri-arteritis) of the retina. This has been verified by John Couper. The observations of Dr. Rayner D. Batten\* made it likely that septic saturation may intensify myopia.

Once I saw capsular cataract with descemetitis supervene in a man of forty from ulceration of the gums, probably of specific character. Mr. Juler of St. Mary's tells me that he too has seen cataract coexisting with intra-oral suppuration.

#### *The Ear.*

Ten persons poisoned by lead had tinnitus aurium, which is a common symptom of sapræmia.

An aching myalgia is very typical of septic poisoning combined with the "fidgets" (anæmia of anterior cornua), reminding us of saturnine muscle ache and of the actions of certain vegetable poisons, such as *actea racemosa*, of *arnica*, *eupatorium*, *baptisia*, and *rhus toxicodendron*.

We have seen that gastralgia of persistent type may arise from passive septic invasion. There is no doubt that many of these cases are associated with unsuspected gastric ulcer.

I shall seek in another place, and at another time, to show that there is a form of gastric ulcer related to Charcot's perforating ulcer and to chronic scrofulous sinus. It is a kind of circumscribed caries of the stomach analogous to dystrophic dental decay. It is a local necrosis of neurotic origin.

#### *The Thyroid Gland.*

I have, in my work on septic intoxication, placed on record some curious examples of paludal and septic goiter.

\* *Ophthalmic Review*, January, 1892.

I say, in deference to ordinary modes of speech, "paludal" and "septic," though in reality these are identical. It may be supposed that marsh miasmata consists of the products of decaying vegetable matter only. But a little thought will remind us that there is no swamp which does not teem with myriads of minute short-lived animal organisms. These perpetually perish and become putrescent. Their toxins mingle with the products of decomposing vegetable life.

Miasmatic invasion and septic invasion are, then, one and the same thing.

The clinical history of the symptoms closely coincide, and the same germicidal remedies benefit both. We have in ague a paralysis of the sympathetic with the natural circulation changed, and the same arrest of hæmatopoiesis as in passive septicæmia. The stress of ague may fall in the woman with its greatest impulse on the nervous system, in men on the articulo-muscular apparatus.

The influence of the miasmatic poisons may forsake the general nervous system and confine its effects to the floor of the fourth ventricle, and thus lead to goiter. In the same way some persons exposed persistently to ordinary toxins will, instead of rheumatism or neuralgia, show a bronchocele with or without proptosis.

SOME REMARKS IN REFERENCE TO THE PAPER OF DR. EDWARD BLAKE ON "SEPTIC INVASION." BY M. O. TERRY, M. D., UTICA, N. Y.

The paper which we have just heard is one deserving of our serious consideration. Its clinical aspect makes it exceedingly practical, and causes us to wander into other fields in the line with the subtle invasion of sepsis of various forms. Many years ago I noted the fact that a mother lost her life by kissing her son, who had died of a malignant diphtheria. It has frequently come to my notice that

syphilitic sores have been contracted in kissing. Recognizing the fact that there are many diseases septic in character which may be communicated from person to person, I took the position in a public address delivered five years ago in which I criticised the manner of administering communion service as given by all Churches excepting, I believe, the Roman Catholic. I have recently noticed that this subject has been under serious consideration by the secretary of the State Board of Health of Ohio. Only a few months since I had a very peculiar case of septic invasion. I had a case of hysterectomy nearly well; in fact the patient was sitting up. The abdominal cicatrix was nearly healed. All of a sudden to my surprise one day I found my patient having a temperature of 105°. As she had been given vaginal douches I became suspicious at once that septic material had been introduced in this way. I found that I had good reason for my suspicion, that the douche tube had been used on other cases, and that simply carbolic acid had been used for cleansing it. Carbolic acid has its sphere of usefulness, but is hardly adequate as an antiseptic to destroy certain septic germs. I had an opportunity of proving that a few years ago when I poisoned two of my fingers. I tried a crystal solution of carbolic acid on one, and a strong solution of nitrate of silver on the other, but still my fingers continued to suppurate. I was speedily relieved, however, by a solution of bromine (1-100)—one of the most wonderful remedies we have in the materia medica for poisonous wounds of all sorts. We have a sample of septic invasion in that plain everyday boil, when it becomes a grandfather in its carbuncular state, the pus cell insinuating itself into the surrounding connective tissue, or when it is carried by the lymphatics to other parts forming focal centers for septic invasion, which begins as a small boil, developing frequently into a carbuncle. The practitioner of to-day, if enabled to carry out his instructions in a case of diphtheria, no longer fears what was once an expected direful result of his case,

for scientific medicine has shown that a thorough and constant disinfectant applied to the throat night and day so completely as to thoroughly remove every vestige of odor will prevent the septicæmic and destructive invasion of ptomainic poison. We believe the paper of Dr. Blake will be suggestive for many more causes of septic invasion, a few of which I have mentioned being samples of the numerous causes which, if they remain unnoticed, cause the death of many a patient.

THE RELATION OF SURGERY TO GYNECOLOGY. BY  
CHARLES E. WALTON, M. D., CINCINNATI, O.

Some years ago there appeared in Madison Square, New York City, a colossal hand; neither its functions nor relationship were readily discerned. It projected above the greensward as though some mighty Titan had been poorly buried, or as though some mythical creature were again emerging from the dreamless sleep of an ancient sepulture. Though bared to the wrist only, it towered high above the head of the observer, who gazed with awesome curiosity upon this emblem of marvelous skill and power, and wondered at its significance. It was the hand of Bartholdi's goddess, destined to light a universe.

Years passed, and across the water the body of this famous goddess was assuming form under the deft direction of its originator. When the hand was next seen it had abandoned its long divorcement, and appeared as the crowning glory of the statue, piercing the blue ether far above its Parisian surroundings, and ready to again cross the ocean, leading the fair goddess to her permanent home, where she should stand beneath the effulgence of its radiant torch. There she stands to-day, personifying "Liberty enlightening the world."

The relation of surgery to gynecology is not unlike that of the torch-bearing hand to the goddess of Bartholdi,

which symbolizes the growth of medical art, illumines the entire gynecological structure, and throws its light upon the whole world of medical science.

What has surgery done and what is it doing to merit so great an encomium? It has turned, and is turning, doubt into certainty, ignorance into knowledge, insecurity into safety.

Gynecology was but a stumbling and a halting child before the strong hand of surgery led its wavering footsteps firmly by the pitfalls of uncertainty, and developed its unsteady gait into the sturdy pace of athletic progress.

For the purposes of this paper we take gynecology to mean that branch of medical science which pertains to the anatomy and physiology of the special organs of generation and their immediate surroundings; the ætiology, pathology, and management of their diseases. As the management of gynecological cases must be either surgical or non-surgical, we take the term surgery to mean that science which develops the principles of mechanical and operative procedures for the relief of any disease, and determines the principles of their application.

It is not the intention to institute invidious comparisons between operative and non-operative methods of treatment, for they are so intimately joined and their objects so identical that they must ever be considered as forming a union whose unity of purpose is its strongest bond, but still it may not be unprofitable to pass in review the achievements of surgery which have brought fame to gynecology.

The progress of gynecology during the last twenty-five years is marvelous, but rendered so by the triumphant march of surgery, which, like a veritable Moses, has led, and is still leading, the gynecological hosts up out of the wilderness of crudity. The scalpel in *living* tissue is the open sesame which unlocks both pathological and func-



tional mysteries, and brings nearer to our grasp the very secret of life itself.

Before passing to the consideration of specific performance let us emphasize the fact that in antisepsis, or the more refined asepsis, we have the foundation for the brilliant surgical exploits of which we are so justly proud. The renown of surgery no longer depends upon the glamour of *exceptional* success, but upon that uniformity of result which must ever follow the recognition and application of universal principles. Primitive surgery and modern surgery do not differ in the application of the principles of antisepsis, but in the development of principles which govern the process of repair and the recognition of pathological methods, and a new insight into physiological function. Primitive surgery was of necessity external surgery and experimental. The auto-amputation of extremities led to imitative surgical procedure. Modern surgery, and especially gynecian surgery, is *internal* surgery and demonstrative, and marks the highest degree of adaption of principles deduced from external work. The so-called citadels of life are no longer defended against ~~operative~~ attack, yet here as in primitive surgery we work upon the periphery.

Accidental surgery has been the precursor of deliberative imitation; the tamping rod emphasized the use of the trephine; and the ripping horn of the infuriated animal, while it led us to fear the bull more, has certainly caused us to dread the peritoneum less. Two cavities were thus opened whose viscera are now daily attacked by the knight of the bistoury.

Primitive abdominal surgery was first confined to the repair of accidental injuries. When the intestines protruded through a wound in the abdominal wall the prudent surgeon cleansed the bowels and replaced them, sewed up the rent, and gave his patient rest: a rest which was not always the one which knows no waking. When the intestines were wounded, however, long and patient study was re-

quired before modern surgery evolved the rule which not only justifies but commands the immediate laparotomy which furnishes exact scrutiny of the parts injured, and an opportunity for the application of exact operative methods. In this gynecology has been the gainer. The operative problems which have been presented to the gynecologist have many times been solved in advance through the development of surgical truths and principles, which are found to be the most valuable when the most general in their application. When the harassed gynecologist of the non-operative type has exhausted all the resources of mechanical and medicinal methods in the vain endeavor to restore a retroverted uterus, and asks of surgery for assistance, the answer comes unhesitatingly—open the abdomen, release the adhesions, and anchor the uterus to the abdominal wall; or, after the method of the Alguie-Alexander-Adams operation, take a reef in the round ligaments.

Are the ovaries and tubes caught within the octopus grasp of a pelvic inflammation and deprived of their liberty of action, the appendages are removed, and the patient relieved at least of one great source of irritation or nerve waste. Do they develop a cyst whose ever increasing pressure not only imperils the comfort, but the very life of the patient, surgery leads the gynecologist to remove the cyst as soon as discovered, and not to still further jeopardize the patient by inane assaults of the aspirating needle. Does a persistent intra-metritic hemorrhage drain the vitality and resist the "indicated remedy," surgery cures that uterus, clearing it of placental *débris* or granular proliferations, the devastating current is stayed, and damage soon repaired.

Has a cervix or perineum yielded to the force of a parturient assault, surgery restores the autonomy, saving the patient, on the one hand, from a cancer-breeding nidus, and, on the other hand, from a displacement courting impairment.

Do fistulæ deflect the natural course of rectal and bladder contents, the surgeon's skill repairs the openings, and the excretory channels resume their normal functions. Does vesical wall or rectal pouch encroach on vaginal space, the surgeon, with the skill of a *modiste*, takes a tuck in redundant tissue, and each viscus is restored.

Does the sturdy gonococcus, ambitious to conquer new territory, invade the secluded precincts of the fallopian tube, and there multiply and replenish its pus until the confines of its operations swell to dangerous proportions, surgery again rescues the patient, and puts those tubes where the coccus must cease from troubling, and menstruation takes a rest.

Does the erratic myoma explore peritoneal space, or seek the outer world through polypoid transmigration, or stay at home and enjoy its intra-mural development, it falls a prey to the surgical poacher, who does not hesitate to remove not only the game, but the very preserves in which it abounds.

Does that great enemy of womankind, the cancer, attack with all its malignancy the primitive home of fetal nativity, and seek to overthrow, with inevitable encroachment, the temple dedicated to the cause of maternity, the alert gynecologist knows that the only hope of rescue lies in a total surgical ablation. Medicine has not yet furnished the remedy, and surgery at best furnishes only a possible reprieve.

Does pelvic inflammation run riot in the delicate tissues, which, from the uterine surroundings, and by the violence of its assault, melts all before it in the fury of a purulent conflagration, the early relief of the surgeon's knife furnishes the speediest means of staying its ravages and supplements with potent co-operation all therapeutic endeavor.

Does pain, with continuous grasp, wring from the chronic sufferer the imperative cry for help, and surgery, with deft skill, removes the innocent appendages and leaves the pain

behind, gynecology has even then been a gainer, and diagnostic acumen receives a new impetus, and finds in the uterine cavity the hitherto unsuspected pathology.

Does gynecian physiology look to the ovaries for the explanation of menstrual phenomena, and call upon surgery to remove them in the vain hope of preventing the periodic flux, it finds that the unsacrificed tubes have a function which has certainly been overlooked.

Does the wily tumor, with almost sentient perverseness, defy diagnostic skill, the scalpel lets in the searchlight of observation, and the wandering kidney, the cystic kidney, the hydronephritic cyst, the renal calculus, the mesenteric sarcoma, the tubercular agglutination, the lithopedion, the stay liver, the malarial spleen, the pancreatic cancer—all are revealed, and a prediction saved from a diagnostic defeat.

Does the question arise whether ovarian autonomy depends upon uterine persistence, the hysterectomy determines that ovarian life is a separate life, and exists just as certainly as the human face after the mirror which reflects it is shattered.

Does a tuberculous peritonitis invade the abdominal cavity, thickening the delicate lining of that enormous lymph sac, studding intestinal wall, and swelling mesenteric glands, surgery gives gynecology another triumph, and by its exploratory incision changes the whole aspect of affairs; a pathological miracle is wrought, and the grave literally robbed of its victim.

But enough! Why multiply examples? Modern gynecology is a splendid structure, but the hand that holds the torch is the hand that holds the knife.

DR. HANCHETT of Omaha.—I am not here to criticise this noble paper which has been read, but to say amen most heartily to it. I make no claim to being a gynecologist. I treat some cases in my office as all physicians in general practice do, but I want to say to every general

practitioner here to-day, when you have a case of operative surgery in the line of gynecology send it to a specialist. I have seen in my own city, and many of the western cities in this country, many a life lost by foolish operative surgery on the part of so-called gynecologists who did not understand their business.

DR. PHOEBE WAITE, New York.—I have enjoyed the paper most heartily. I am frequently in the habit of passing down the bay in New York, and observing Liberty Enlightening the World—a beautiful statue, to be sure—and I admire the application made in the paper. However much I may admire surgery, I would make the plea for medical treatment in gynecological practice. I believe the surgeon has come to be prominent in gynecological practice, and surgeons and physicians are too fond of using the knife. I have seen too many young women who have passed under the surgeon's knife, from whom the ovaries have been removed, single women and married women, who in my opinion might have been spared this infliction, because it is a very great infliction. I have in mind a beautiful young wife who came to me about nine months ago in a very despondent frame of mind, very much distressed over a diagnosis which had been made in her case, and she had been told there was no help for her except in the removal of the ovaries. Said I, "You are a stranger to me, but if you were my daughter I would as soon you had your head cut off as to have your ovaries removed." She consented to give up the operation, and placed herself in my hands. She had been told that she could have no more children, and she was very anxious to become a mother. I took the case, and three months ago she came to me looking bright and happy, and informed me that she was three months pregnant. So much for taking hold of a case medically.

I have also in my mind a young unmarried woman who suffered from dysmenorrhea; and she passed under this skilled surgeon's hands, the ovaries were removed, and she

did not get better. She grew worse, and to-day she is hopelessly insane. I believe she might have been cured if the homeopathic remedies had been carefully studied in her case.

While, as I say, I have respect for surgery, I have still greater respect for medical treatment.

DR. MARTHA J. RIPLEY of Minneapolis.—I wish to emphasize the remarks made by the last speaker. While agreeing with the very able paper in the cases of dire necessity, I should not be true to my convictions as a physician and as a woman if I did not say call a halt on your operations upon women. It is high time that you did so, because to-day many a woman is being operated on in all of our large cities, and in some of our small ones, who needs no operation at all. I could recall case after case such as has been spoken of here, of women who are to-day in insane asylums. My dearest friend went to her grave a week ago from an operation by a skilled gynecologist. Those operations are needed, but beware how you practice them upon women who do not need them. Practice and study your materia medica. It is well that some of you do live in small towns where you cannot get skilled surgeons, or I fear there would be very few of your women patients left.

Now I am looking in the faces of young men who come here and listen to the words of the older surgeons, and I recall what a student of my own said. He came to me and said he was going to perform what I considered quite a difficult operation on a lady. I said to him, "Do you think you are able to do that—are you skilled enough?" He said, "Well, I have got to learn some time; why shouldn't I begin now?" If you have got to learn upon women go where those who are your teachers can teach you.

You understand that I believe there are operations that are needed, and when needed they should be promptly done, and you that have patients that are beyond your skill send them to those that you think can do better; but I call a

halt upon operations upon women that are being done to-day. Turn to your own sex and see if they don't need it too.

DR. BOOTHBY.—I did not propose to say anything upon Dr. Walton's paper, but it has been criticised in such a spirit that I feel called upon to say a word. I do not believe that my brother Walton intended in any way to convey the idea that unnecessary and improper operations should be made. It is not the skilled surgeon nor the skilled gynecologist that operates when he ought not to. It is in those cases where there is a diseased ovary, or a diseased tube that is beyond curative measures. You know it as well as I do. Every physician that has ever opened the abdominal cavity knows it, and when you come to statistics there is not ten per cent. of fatalities. I would speak very modestly for myself, and say that if 3 cases that were operated on before I came here should recover, it will make 102 successful cases in the homeopathic hospital and my own institution, and that includes 12 or 15 hysterectomies and 6 cases of appendicitis, and the various other cases that come up. When we can do this, and have these results, it is entirely out of place to assume that we are removing a woman's ovaries when we would not do the same thing to a man.

DR. H. W. ROBY of Topeka.—In all medical conventions that I have attended I have heard similar discussions to this, and I believe their necessity grows out of the fact that some minds are organized in one direction and some in another. Some men and some women, in the practice of medicine, give their time and their study and thought along the lines of materia medica and therapeutics; others of surgery, gynecology, and so on; and each becomes enthusiastic in their line and in their specialities, and very often overlook the powers and capacities of the other field of practice.

The thing that we need is to know so much about surgi-

cal capacity and medical capacity and therapeutic capacity that we shall be able to make a wise and just discrimination, and use medicines where medicines are efficient, and where they are inefficient to resort to that which is efficient. I have seen, and you have seen, many a time patients subjected to medical treatment day after day, week after week, and month after month, through long and weary years, without result, whereas if they had been handed over to a skillful surgeon it may be a slight operation might have set them on the pedestal of life and happiness. I plead here for a just discrimination between medical and surgical cases. They are both useful in their place.

Homeopathy has a grand field in which it may be successful, but outside of that field there are other possibilities, other capacities, and other powers. If you have given time and attention to medical practice, do not be too sure that that is all there is within our command for the relief of a suffering community.

DR. H. E. BEEBE, Sidney, O.—To any candid observer it must be plain that progress is stamped upon the doings of everything closing the scenes of the nineteenth century, whatever be the department.

Effective work in all branches of science and art is the basis of success. Specialists are ever in demand. Positive specific results must be attained to merit worthy commendation. To-day "fads" are short-lived; the twentieth century is to be inaugurated with fewer shams. Perfection is the goal in view.

Surgery is not an exception, and it is impossible to ignore the prominence which gynecological surgery has everywhere assumed. It is called to accomplish what non-surgical agencies have failed to do—mechanically correct false physiology and pathology.

Abnormalities are to be ameliorated, and cured if possible, and that too by the most conservative measures. These may be simple methods or the most expert work.



Effective surgery depends upon knowing when to use it. Skill and thoroughness are good operators, but are careless in the subsequent attention. To avoid infecting the wound is as important as brilliant operating.

Surgical diseases of women are no small part of the gynecologist's practice. Of morbid growths alone, both malignant and benign, affecting the human race, more than seventy-five per cent. belong to the female organs of generation, and are either uterine, ovarian, or mammary. With this fact, and knowing that morbid growths are but a small part of the surgical diseases of women, certainly there is a broad field for surgery in this specialty.

About one-third of all physicians claim to be gynecologists. To fully ninety-nine-hundredths of this number the teachings of diseases of women have not been thorough and practical. The average gynecological specialist is capable of doing many of the simple operations through the natural passages, but it is a great mistake for amateurs who have never done major surgery to attempt operations through artificial openings involving the peritoneum, such as are considered in this paper.

The surgical novices have no business doing this internal major surgery. Few gynecologists are trained abdominal surgeons; they have not spent enough time in the study of visceral anatomy in the dead-house, nor been in the clinical fields eyewitnesses to "the scalpel in living tissue" by experienced operators. Training and experienced observation are very necessary for so important a work.

To depend upon self-experience alone to learn major surgical gynecology at the patient's risk is a responsible matter. Abdominal surgery is a specialty within itself, and needs as much preparation as any specialty.

There are too many laparotomies done, and too many untrained operators are doing them, to the great detriment of justifiable work. The surgeon lacks acquired knowledge and skill, besides the facilities for doing good work. Sel-

dom, except in emergency, is laparotomy warrantable without a room thoroughly prepared for it.

Skilled abdominal surgeons to-day have a uniform mortality of only about ten per cent., and a percentage greater than this usually means incompetency. The advance made in this field, and so well shown in the paper, has been by experts well trained in antiseptics, and the anatomy, physiology, and pathology of the female organs of generation. They knew what to do, when to do it, and how to do it. They knew "the relation of surgery to gynecology," and that "the hand that holds the torch is the hand that holds the knife."

PLASTIC SURGERY OF THE VAGINA. BY W. E. GREEN, M. D.,  
LITTLE ROCK, ARK.

There is probably no branch of surgery that requires more thought, ingenuity, and operative dexterity than does the plastic operations for the restoration of the pelvic structures in women. A study of anatomy, physiology, natural and acquired relation of parts, immediate and remote effects of injury and their reflex influences, is essential to a correct understanding of the subject. When the pelvic floor is weakened by a rupture of its supporting structures the function of all the pelvic organs are more or less disturbed, and ultimately the entire human organism may become affected.

The levator ani muscles form the floor of the pelvis. They are two broad, thin muscles, which have their origin principally from the posterior aspect of the body and ramus of the pubes; posteriorly from the inner surface of the spine of the ischium. They pass downward and unite in the middle line. The most posterior fibers are inserted into the side of the rectum, blending with the sphincters.

The transverse perinei arises from the inner side of the tuberosity of the ischium, and is inserted into the sides of

the sphincter vaginæ and levator ani. These, in conjunction with other less important muscles and the fasciæ, make up the perineal body. The levator ani, which constitutes the bulk of the perineum, supports the lower end of the rectum, the vagina, and the bladder. A rupture of these parts, such as often occurs during labor, disturbs muscular equipoise of the region. The torn fibers separate; the transversus perinei muscles, instead of holding the central raphe in a state of tension, pull open the vaginal orifice. The anus is drawn upward and backward toward the coccyx. The fascia, having lost its attachments, allows the anterior rectal wall to pouch forward, forming a rectocele, which drags its vaginal wall downward. The vaginal muscle, which has its principal attachment to the recto-vaginal fascia, loses its tonicity, permits the cervix to fall forward, changing the position of the uterus, which becomes more or less prolapsed, dragging downward the bladder, preventing its entire evacuation, which causes increased relaxation and stretching of tissue, cystocele. The blood vessels having lost their support, a general venous stagnation, with its consequent engorgement of the pelvic viscera and discomfort, ensues.

The variety and complexity of vaginal and perineal tears are indeed surprising. It has always been my habit to make a careful inspection of the parts after every confinement, and I believe that I have seen almost every form that could be produced. The orthodox central lesion is the most frequent, but not by any means the most injurious. Lateral internal vaginal ruptures that are often made with the tip of the blade of the forceps when removing it, before the head is born, are among the most mischievous. I have seen these extend from near the cervix uteri to the vaginal orifice, the outside structures being intact, and so deep that the cellular fat protruded through the gap. A superficial observer would never have detected them. An infrequent tear, of which I have seen three, is where the vaginal outlet is torn

away from its attachments, being pushed forward by the head, the mucous membrane gives way just within the orifice. The most extensive one extended upward on either side almost to the urethra, and downward to the sphincter ani muscle, making a pocket-like chasm, in which the four fingers of the hand could be inserted. A small central laceration, through which the child's shoulder emerged, existed, yet the sphincter was not torn. Another almost significant lesion that is often overlooked is where the muscular structures of the perineum are torn in two and the skin remains uninjured; these tears are often deep, form pockets for the retention of septic matter, do not unite, but granulate, and form large cicatrices, and yield disastrous results to the pelvic viscera. A rare condition that I once repaired was an oblique laceration,  $1\frac{1}{2}$  inch long, that existed well forward near the urethra. It bled furiously, and was difficult to close. I have repeatedly seen a submucous separation of the perineal structures where the mucous membrane of the vagina and the skin on the outside remained intact.

The power to prevent many of the severe disasters to the general health that follow ruptures of the perineum and vagina lies with the accoucheur. It is his imperative duty to make a critical examination of the genitalia after every labor, and if he finds any form of rupture, it matters not how insignificant it may seem to him, it may in some remote way produce trouble, therefore it should be repaired before he leaves his patient. This should be done in the most systematic and painstaking way. If necessary an anæsthetic should be given. The genital tract and adjacent parts should be most carefully cleansed and douched with an antiseptic lotion, the torn surfaces trimmed of all ragged and contused tissue, rendering the parts even and clean cut. The wound should then be closed with two sets of catgut sutures, deep and superficial, coaptating like structures. Too much care cannot be exercised in doing the operation.

If properly executed the results are most satisfactory, and failure will rarely follow.

When a laceration has been sustained and the evil consequences manifest themselves, the case then becomes one for the surgeon's consideration, and the question that confronts him is, how can a restoration be accomplished? how can the overdistended and everted vaginal tissue be replaced, and the proper support given the pelvic viscera and blood vessels? The stagnant capillary circulation is relieved, the hyperplasiac deposits absorbed, the hypertrophied organs reduced, and a healthy function restored.

The operator who does not fully appreciate the requirements of each case, and deals with it according to its individual demands, but simply endeavors to restore an imaginary perineum, a dam-like obstruction to the prolapsing structures, will meet with disappointment in almost every instance.

The time allotted to read a paper does not admit of my taking up the entire list of plastic operations upon the vulva and vagina, therefore I shall only attempt to deal with three, viz., removal of scars, cystocele, and perineal injuries.

It is an established truth with all close observers who treat diseases of women that cicatrices of the vagina produce both local and reflex irritation, disorder the nervous system, and thereby more or less impair the entire bodily nutrition; and I will say here, for the benefit of those who oppose an immediate repair of vaginal and perineal lacerations, that it is bad surgery to leave any wound of those parts, whether it occurs during parturition or from other causes, to heal by granulation. For aside from the ultimate injury that the pelvic viscera sustains, these reflex troubles may arise, and will yield to no treatment excepting the removal of the scar. Considering the above facts, amputation of the uterine cervix or operations about the vagina ought not to be performed with either the *ecraseur*

or the galvano-cautery. The knife or the scissors should be used, and the denuded surfaces covered with mucous membrane.

These scars of the vagina demand serious attention at the hands of the surgeon; they should be managed with the same care accorded laceration of the cervix. All tender or contracting cicatrices should be dissected away, and the resulting wound closed with sutures. Remnants of a lacerated hymen and thickened and sensitive nymphæ should be excised, excrescences about the meatus clipped away, adhesions of the clitoris broken up, and, if necessary, a V-shaped piece cut from the hood.

*Cystocele*.—A cystocele is a pouching deformity of the anterior vaginal wall, caused by a laceration or an over-distention of the structures. It contains the base of the bladder, and is gradually increased by the frequent straining at micturition, an ineffectual effort to evacuate the urine that constantly remains therein; the constant irritation increases the vascularity and causes a thickening of the walls. The condition is one that entails great suffering, and is often overlooked by operators. Like other conditions about the vagina that demand repair, many devices, some of them extremely complicated, have been instituted for its correction. Its successful management is simple enough if the requirements are fully understood. The object sought is to change the convex to a plain surface; take all the slack out of the anterior vaginal wall, but do not shorten it to any great degree. No stereotyped or set rules can be laid down to govern beforehand the amount of tissue to be removed, or to designate the shape of the denuded surface.

Before beginning any of the operations for the repair of the vaginal or perineal structures it is proper to dilate and curette the uterus, if necessary, and repair any laceration of the cervix that may exist. If the cervix be badly diseased, as it often is in old subjects, an amputation is

demand. All the required operations may be done at one sitting, or divided into two, as the necessity of the case demands. It has generally been my habit to do the operations upon the womb and anterior vaginal wall first, leaving the rectum and perineum for a subsequent time, before the patient leaves her bed.

With the patient anæsthetized and in the lithotomy position, with the parts in an aseptic condition, the surgeon takes a sharp tenaculum in either hand, hooks them in the mucous membrane on either side of the cystocele, and draws the tissue to the center until all the slack has been taken up. In this way he estimates the amount of tissue to be removed, and, in his mind, outlines the shape and extent of his incision. It is often the case that a urethrocele coexists, when it will be necessary to carry the dissection well up to the meatus. At times the broadest area may be near the os uteri. After making out the area to be denuded, as before described, the vaginal wall is seized in its central line by one or two pairs of T forceps, which are held and drawn forward by an assistant. Then with a sharp scalpel, beginning down at the os uteri, an incision that extends through the vaginal muscle is carried forward on one side along the line of election to near the meatus; another one, in like manner, is made on the opposite side. Then with a few strokes of the knife the loose cellular tissue which connects the vaginal muscle with the bladder is divided and the flap removed. Any irregularity or unevenness of the surface may then be cut away with a pair of sharp scissors. The bladder is then evacuated with a catheter, the parts irrigated with hot water to control the oozing, and the sutures introduced. This should be accomplished with medium-sized catgut introduced in two rows, deep and superficial. Beginning at the cervical end of the wound, the needle is introduced just within the cut surface, so as not to include the mucous membrane, and made to pass straight through across, and emerging in the

opposite side a like distance inside the cut surface. A continuous or running stitch is carried in this way up to the meatus, and the end left long. Commencing at the same point, another row of sutures that take a strong hold in the mucous membrane is introduced. The two ends that emerge at the meatus are tied. This closely unites the divided edges of the mucous membrane and makes a strong seam, and is a successful measure. The posterior vaginal wall is then treated according to the demands of the case.

Various changes follow laceration in the pelvic floor, depending upon the amount of injury done; therefore a satisfactory management of the condition depends upon a restoration of the natural atomical relation of the parts. This cannot be done by a superficial denudation of the mucous membrane. The mucous membrane and sub-mucous tissue, down to the muscular structures, must be dissected up and all scar tissue removed (scar tissue is wanting in vascularity, and does not unite well), like tissue brought together, and the normal contour restored. To accomplish this established operations will not answer; every case must be a law unto itself, and the individual requirements must guide the surgical procedure. I can probably give a clear idea of my views by dividing perineal operations into three classes: 1st. Where the tear is of moderate extent, and not extending far up into the vagina. 2d. Where the tear is deep, extends well up into the vagina, and a resulting rectocele exists. 3d. Where the sphincter ani muscle is involved, a complete laceration.

The operation for the first condition is simple and easy of execution. The sphincter ani muscle having been stretched, and the lower bowel evacuated and thoroughly douched, the labia is seized at its muco-cutaneous junction on either side with a pair of T forceps, just anterior to the point to which we intend to carry the dissection. These are handed to an assistant, who puts the parts upon the



stretch laterally. One or two fingers are then introduced into the rectum as a guide, while a sharp scalpel in the right hand is entered flat-wise at the raphe and pushed inward toward the os uteri, beneath the vaginal tissue, to the point that it is desired to carry the dissection, the highest point of the tear. With a sawing motion, the flap is loosened up on either side; then with the scissors a pear-shaped piece is cut out of the flap. With a curved needle threaded with medium-sized catgut, beginning above, two or three deep sutures are taken at right angles with the axis, the last one lying just inside of the vaginal outlet, drawn moderately tight, securely tied, and cut short. Then, beginning at the highest point in the vagina, a superficial row of sutures is supplied, which coaptates the mucous membrane in the vagina and the skin on the outside, the parts dusted with iodoform, and a strip of iodoform gauze, for protection and drainage, applied. This is removed at the expiration of the fifth or sixth day, and a vaginal douche used every twelve hours.

This gives a most satisfactory result. The process of healing is comparatively free from pain; there is no cutting of stitches, swelling and distortion of parts, and consequent cicatrices and unevenness of surface, as in the older methods; and if the operation has been dexterously done the parts present an appearance that is not distinguishable from the natural condition.

When a rectocele exists the preceding operation is somewhat modified. The dissection is carried much higher, the recto-vaginal septum is divided well up toward the uterine cervix, but the flap is only cut away as high as the internal perineal border. Beginning at the highest point at which the recto-vaginal septum was separated, a needle threaded with a medium-sized catgut is entered on the left side and made to penetrate the flap, carried across the space, and brought out in the vagina on the right side, re-entered one-third of an inch near the vaginal outlet, again passed across

the space, and brought out in the vagina at a like distance (one-third of an inch) from the first point of introduction. One or two of these sutures (as may be necessary) are introduced, then tied in the vagina, bringing together laterally the cut surfaces, making a heavy ridge in the vaginal floor, taking up all the slack tissue. The outer part of the wound, from which the flap has been cut away, is then closed, as in the previous operation. This procedure not only eradicates the rectocele, but gives an additional posterior support.

When complete laceration of the perineum exists, greater complexities follow. The torn muscular fibers contract and atrophy from non-use; the severed ends of the sphincter muscle separate and retract; there is a thinning and stretching of the recto-vaginal wall; relaxation and sagging of the vagina, and, at times, prolapsus of the rectum. All these conditions must be considered and corrected. The operative measure adopted must be one that will establish the normal relation of the several parts, support the pelvic viscera, relieve the overdistended circulation, and restore the functional activity of the sphincter ani muscle.

From the many different methods in vogue for the repair of a complete laceration, and from the fact that I have known patients who have been operated upon two or three and even four times without successful issue, I am led to think that perfection in method is yet to be desired. In fact even in partial ruptures I have, on several occasions, been called upon to do the work again where other reputable surgeons had failed in their efforts. Indeed my successes have been very flattering. I have the record of over one hundred consecutive cases without a single failure.

For the restoration of the perineum in complete laceration I have devised the following method, which in my experience meets all the requirements better than any other. I have now performed it many times, with complete success in every instance. The healthy bowel

brought down, protects the wound from infection, and obviates the necessity of rectal flaps and bringing stitches into the gut, with its attendant danger of rectal fistula.

First rendering tense the recto-vaginal septum with two pairs of T forceps in the hands of assistants, an incision is carried along the line of junction of the rectal and vaginal structures, and then upward on either side to the highest point of the tear, splitting the recto-vaginal septum, and dividing the skin from the vaginal mucous membrane; after which an anterior vaginal flap is dissected up to the desired extent. The first step of the American operation is then done, viz.: the mucous membrane of the gut is seized on a line with the upper border of the internal sphincter, drawn down and divided all round by a circular incision, dissected down and removed at the muco-cutaneous junction. The ends of the torn sphincter are next loosened up and secured with medium-sized catgut, uniting them accurately. If there is much tension upon the parts two or three heavy silk approximating ligatures should be introduced, taking a good hold on either side, as in an ordinary perineal operation. The deeper portions of the wound are then brought together with buried catgut, so as to leave no gaping spaces, the silk ligatures tightened and tied, the flap trimmed up, and the necessary coaptating catgut sutures applied. The gut is then grasped with forceps, drawn down, and united all round to the skin, completing the American operation.

[*Other Papers read at the Congress will appear in July number.*]

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—THE subject of position for the relief of the distressing nausea and vomiting of pregnancy is treated very ably by Dr. Henry Sherry, Chicago, in the *Medical Current*. In the case reported the woman had one child three years of age; in the second pregnancy the nausea and vomiting began in the second month, and in spite of all treatment could not be checked, the woman aborting at the end of the third month. This condition of affairs con-

tinued during the two following pregnancies, abortions occurring at the third month. In the fifth pregnancy the vomiting was very severe, and abortion seemed again imminent, when the woman was placed upon a couch the foot of which was elevated twenty-four inches, and kept in that position for twelve hours, after which she was placed upon the bed for another twelve hours. This treatment was continued for one week, the nausea and vomiting gradually becoming less and less, until at the end of the week she was able to take and retain solid food.

With only slight attacks of nausea she remained in these positions until the end of the fourteenth week of pregnancy, when she was able to sit up in bed, and in ten days was able to go about the room, after when she was treated by massage, and went on to full term.

—A UTERUS IN A SCROTUM.—A curious case of hermaphroditism was recently reported by M. Boekel to the Academie de Medicine (*Lancet*, April 30, 1892). A man, twenty years of age, has had since birth an inguinal hernia, to relieve which an operation for radical cure was undertaken. The hernial sac was found empty, but in its posterior wall there was found covered by peritoneum a triangular body, which was supposed to be an intestinal diverticulum. Further examination, however, showed that the inguinal canal was empty, and that the organ in question had no connection whatever with the digestive tube, compression of the abdomen above the ring resulting in the extrusion through the external inguinal ring of an ovoid pearly body resembling the testicle. Lying parallel to and above this body, and united to it, was a fringed cystic organ which could not be anything else but the fallopian tube. All these structures were carefully isolated by dissection and extirpated. Cicatrization was complete at the end of ten days. Examination of the extirpated mass revealed (1) a bicornate uterus, the mucous membrane of which was lined by ciliated epithelium; (2) a fallopian tube and a testicle provided with an epididymis and a vas deferens; (3) a broad ligament inclosing these organs. This is the only known example of female sexual organs being contained in the scrotum of a man. The patient's appearance and habits were entirely those of a male.—*New York Medical Times*.

# THE HOMEOPATHIC JOURNAL OF OBSTETRICS, Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

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## CÆSAREAN SECTION.\*

BY

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CLEVELAND, O.

*Historical and Statistical.*—Leishman says that Cæsarean section, with its perfection in detail of operation and splendid results, is of modern date. It is true that it has a history dating back to Numu Pompelius, who “forbade the burial of pregnant women on whom the operation had not been performed.” We have no early authentic statement that Cæsarean section was performed upon living women. Though no mention is made of it by the old writers, such as Hippocrates and others, yet its great antiquity is admitted.

The first mention of Cæsarean section is in the “*Chirurgia Guidonis de Cauliaco*,” published in the middle of the fourteenth century, and here only after the death of the mother. It was performed the first time on a living woman

\* All articles printed in this issue were delivered before the World's Congress, June, 1893, and stenographically reported for this journal.

in 1500 by Jaques Nufu, on his own wife. At first no attempt was made to close the uterine wound, for all the attention seems to have been given to the manner of closing that of the abdomen. In 1769 Libas was the first to close the uterus with sutures after the operation, but this proceeding was lost sight of until 1828, when it was carried out by Dr. Frank E. Pollin, who first used the silver wire suture for the uterine wound.

Sir F. Gould, in 1742, is the first British author who notices the operation, and says it may be performed "either while the mother is living or after her death."

The Cæsarean operation meant one of three different proceedings, viz.:

First. Cutting the os when hard, fibrinous deposits are found around it, or when other conditions exist which necessitate its opening and enlargement; this is vaginal Cæsarean section.

Second. Abdominal Cæsarean section for the removal of the fetus from the abdominal cavity, or *ectopic gestation*.

Third. Cæsarean section where the incision is made through the abdominal and uterine walls for the extraction of the fetus. In abdominal section there are three conditions which indicate the operation, viz.:

First. When the fetus is alive and the mother died in labor, or in the last two or three months of pregnancy.

Second. When the fetus is dead, but cannot be delivered in the usual way on account of the deformity of the mother or the disproportionate size of the child.

Third. When both the mother and child are living, but delivery cannot take place from the same cause as in the second example.

History records the bitter opposition to the operation, as well as the strenuous efforts made to support it, during the seventeenth and nineteenth centuries. To-day it is an accepted operation under existing conditions with results favorable.

The conditions which warrant the operation are largely disputed. In Germany it is asserted that it should be performed where the conjugate diameter of the brim is only  $2\frac{1}{2}$  inches. Americans say that craniotomy can be performed where the diameter is only  $1\frac{1}{2}$  inch, but the conjugate is *not* the test.

"Cazeau thinks the operation is indicated when the pelvic contraction measures five centimeters (two inches), and Tarnier is of the same opinion. De Paul prefers the Cæsarean section when the pelvic contraction is only six centimeters and the child is alive."

"Scanzone would even prefer the operation for a living child if the contraction was only eight centimeters." This diameter may be from  $1\frac{1}{2}$  inch to  $2\frac{1}{2}$  inches, and other conditions exist which demand the procedure. These conditions may be a shelving brim, an exostosis, a fibroma, pelvic hematocele, cellulitis, malignant neoplasms, fracture of the pelvic bones, spondylolisthesis, placenta prævia, the kyphotic pelvis, the scoliorachitic pelvis, the Roberts pelvis, the osteomalacia pelvis, or the ruptured uterus. Moreover, the operation is indicated in cases in which the mother *prefers* the operation rather than to sacrifice the life of the child; also in cases of death of the mother while the child is viable.

The following statistics by Schroeder, up to 1874, gives the percentage of deaths at 54 per cent. Dr. Robert P. Harris gives the following statistics of operations: in North America 135 cases with 60 cures; in England 141 cases, 25 cures. He further states that in 120 operations in this country the percentage of cures in the country was  $62\frac{1}{2}$  per cent., in the small towns 34 per cent., and in the cities 33 per cent. The same authority, in a report dated September, 1886, gives the results of Cæsarean section performed when the condition was favorable, viz., saved, 75 per cent. of the mothers in this country, and 80 per cent. of the children. It further gives a statistical report as follows:

Cæsarean operations of the United States, . . .	144
Women saved ( $37\frac{1}{2}$ per cent.), . . . . .	54
Children living when delivered, . . . . .	64
First fifty operations saved (54 per cent.), . . .	27
Last fifty operations saved (24 per cent.), . . .	12
Operations for decade ending Dec. 31, 1855, . .	25
Women saved, (48 per cent.), . . . . .	12
Children living, . . . . .	13
Operations for decade, ending Dec. 31, 1865, .	24
Women saved ( $45\frac{1}{2}$ per cent.), . . . . .	11
Children living, . . . . .	10
Operations for decade ending Dec. 31, 1875, . .	36
Women saved ( $27\frac{1}{2}$ per cent.), . . . . .	10
Children living, . . . . .	11
Operations for $10\frac{1}{2}$ years ending Aug. 1, 1886, .	37
Women saved ( $21\frac{3}{4}$ per cent.), . . . . .	8
Children living, . . . . .	16
Late operations (nearly 84 per cent. of this division), . . . . .	31

The late Dr. S. S. Lungren of Toledo, O., collected reports of all cases on the same women. On 48 women the operation was performed 119 times; 8 mothers only have died, and 40 have been saved.

"The time most favorable for the operation is that which just precedes or immediately follows the rupture of the membranes, for at this time the os is well dilated, and the uterine contractions, which have already existed for some time, acquire a more regular and intense character. If one operates much earlier than this the uterine contractions after the operation are apt to be insufficient, and if much later the danger to the child is considerably increased."

Statistics vary; one report gives the advantages of an operation during or before the close of the first day of labor to be 73 per cent. of women, and 86 per cent. of children, while Lusk says only 81 per cent. of women are saved.

Dr. Harris gives statistics as follows: 24 hours before



labor had commenced, 7 operations, 7 cures; 34 hours before labor had commenced, 7 operations, 4 cures; 34 hours after labor had commenced, 10 operations, 1 cure.

Radfoot gives statistics of 100 cases as follows: 24 hours before labor, 24 operations, 7 cures; 24 hours after labor, 76 operations, 9 cures.

Kayser's statistics in relation to the rupture of the membranes are as follows: Before or 6 hours after—mothers, 39 cases, 20 cures; children, 39 cases, 34 cures; 7 to 24 hours after—mothers, 35 cases, 24 cures; children, 32 cases, 25 cures; more than 24 hours after—mothers, 38 cases, 13 cures; children, 37 cases, 19 cures.

Of Porro's operation the results for the first few years were very unfavorable. It is reported that the mortality of mothers was 58 per cent. For the period of five years to the close of 1889 from all countries the general result is of 158 operations; there were 47 deaths, a mortality of 29 per cent. Italy, who gave us the Porro operation, and has thus far led all countries in the number of her Porro-Cæsarean exsections, has made the least satisfactory progress in reducing the percentage of death.

Cæsarean operations in the United States where the obstruction was due to uterine fibroids, 13.

Cæsarean operations in the United States where the obstruction was due to pelvic fibrous tumors, 1.

Cæsarean operations in the United States where the obstruction was due to pelvic exostosis, 8.

Women recovered in uterine fibroid cases, 4.

Women recovered in pelvic fibroid cases, 0.

Women recovered in pelvic exostosis, 4.

Children living in uterine fibroid cases, 5.

Children living in pelvic fibroid cases, 1.

Children living in pelvic exostosis, 5.

Time in labor in uterine fibroid cases, 42 hours to 15 days, 9.

Time in saved cases,  $9\frac{1}{2}$  hours, 14 hours, 3 days, 4 days respectively, 4.

Time not stated, but labor prolonged, 2.

Time in labor in pelvic exostosis cases, 24 hours to 3 days, 6.

Time in saved cases, "a few hours," 12 hours, 24 hours, and 38 hours respectively, 4.

Uterine fibroids cases saved,  $30\frac{1}{4}$  per cent.

Pelvic exostosis cases saved, 50 per cent.

#### *Modifications of the Operation.*

1. Porro's Cæsarean section, ovaro-hysterectomy: "Amputation of the uterus and ovaries immediately after performance of Cæsarian section, the stump being fastened at the lower angle of the abdominal wound."

2. Thomas' operation: "Laparo-elytrotomy."

3. Porro-Muller operation: In this the uterus is brought out of the abdominal incision, an elastic ligature is applied around the cervix at the level of the internal os, and the uterus is then incised and the fetus extracted.

4. Porro-Veit operation: "Modification of Porro's operation by dropping the stump into the pelvis."

5. "Sanger's operation": "Sero-serous."

6. Pubeotomy.

#### *Necessary Steps in the Operation.*

First. Care for the patient in every particular as in coeliotomy.

Second. The abdominal incision should be sufficiently long to permit the lifting of the womb out of the abdominal cavity.

Third. Protect the exposed uterus with hot cloths.

Fourth. Have a *heavy* rubber tubing passed around the cervix uteri, and tie in a single knot loosely; it may be useful in case of hemorrhage.

Fifth. Surround the lower part of the uterus with ster-

ilized or medicated gauze, thus preventing soiling the abdomen.

Sixth. Open the uterus and remove the child and placenta.

Seventh. If severe hemorrhage occurs seize the uterus with the hands, and gently or otherwise contract the uterus. Ergot may be necessary, or tighten the rubber tubing.

Eighth. After cleaning the cavity of the uterus close the uterine incision with sutures. Silver, silk, or catgut may be used, adopting one of two ways, viz.:

1. The deep suture, avoiding the mucosa, with superficial intervening suture. 2. The symperitoneal suture, or the "sero-serous" of Sanger.

Ninth. Close the abdominal wound with silkworm gut sutures after the manner of cœliotomy, and the usual anti-septic dressings.

#### *Clinical Cases.*

CASE I. Cæsarean section. Mother and child saved. Mrs. A. Salter, a German, of Salineville, O., æt. twenty-eight, weight sixty-five pounds, height four feet, husband's height four feet nine inches. This is her fourth impregnation; in the three previous gestations the lives of the children were sacrificed at full term by craniotomy.

The parents were desirous of having a living child, and the mother was willing to assume the risk of a Cæsarean section.

Two weeks before the time of the completion of term Mrs. S. came to the Huron Street Hospital in Cleveland, O. At the completion of her gestation, at 7 A. M. December 15, 1886, labor pains began and continued till nine o'clock on the evening of the same day. Professor J. C. Sanders was in constant consultation during the day and up to the time of the completion of the operation. Professor Sanders after his first careful examination of the patient believed that

by turning the fetus in utero a living child could be born. At nine at night when the os was dilated to the size of a silver dollar, and before the membranes had ruptured, the doctor decided that it would be impossible to deliver the child alive *per vias naturales*—a wall of bone, the shelving brim of the plevís, obstructing the passage, and the conjugate diameter being less than two inches. Anticipating his decision, every preparation was ready for the operation. The babe was living, and the heart beats were 135 per minute. The London mixture was used, and in fifteen minutes after beginning the operation a living girl babe was extracted from the womb through the abdominal and uterine walls. The operation was performed in the operation room of the hospital before the senior class of the Homeopathic Hospital College and other physicians.

#### *The Method of Operating.*

The patient, assistants, nurses, instruments, dressings, room, and furniture were all carefully prepared for the operation. None were admitted who had been dissecting or were in attendance on any contagious or suspicious case within forty-eight hours. The usual cœliotomy incision was made, beginning two inches above the symphysis pubes and extending to a point beyond the umbilicus and in depth down to the peritoneum. When the bleeding was stopped the peritoneum was opened, exposing the uterus. An assistant held the uterus in position by placing the hands on either side of the womb. The sides of the peritoneum coming in contact with the uterus were packed with sterilized gauze, thus protecting the peritoneal cavity from the entrance of fluids. The uterus was entered by an incision eight inches in length in the median line on the interior surface—fortunately the “placental site” was not in danger of being encroached upon by the knife, which brought to view the translucent membranes inclosing the fluids which cushions the babe in its casket like a bird in

the egg. A natural contraction of the uterus, observable by all, ruptured the membranes, the fluid escaped when the infant, doubled upon itself, was exposed to view, and the closest approach to the great mystery of life—the marvel of maternity—it is possible to have enjoyed, was seen by those who reverently witnessed the operation. Some strong men actually wept in witness of the depth of emotion caused by what so few have ever seen, and what no man could see without being profoundly moved—a sight as powerful to move the heart as the view that Moses had of Deity. Every other feeling was completely subordinated to that sentiment of reverence and wonder, which would be natural on being permitted to see what is transpiring on another of the inhabited planets. The presentation was natural. The feet were seized and the babe lifted from the womb and given to Professor J. C. Sanders and Dr. W. L. Sapp to care for. A gasp and a lusty squall, assuring us all of the safety of the babe, elicited a round of genuine but subdued applause, and an exclamation of delight from the father. The cord was secured, and afterbirth and membranes were carefully removed. The uterus was grasped and made to contract. The patulous collum uteri did not need a drainage tube. The cavum uteri was gently cleaned, and the uterus closed with animal ligatures, after Sanger's method. The abdominal cavity was cleaned, the abdominal incision closed with silk sutures, the toilet of the abdomen completed, and the mother put to bed. After a few moments she recovered consciousness, and found by her side a living girl babe. With motherly instinct she drew her child closely to her heart, and greeted her darling's first welcome with the exclamation, "Mein babe!" a salutation that could but feebly express the depth of her mother's love and devotion to those who did not know the risk she had run to save her babe's life. The mother and babe were the recipients of devoted and sympathetic attention by the nurses of the hospital, and both returned

to Salineville after the usual uneventful convalescence of a cœliotomy.

CASE II. Cæsarean section. Mrs. R. T., æt. thirty-four, mother of two living children. From the beginning of her labor was assisted by a midwife for sixty hours. At this time Drs. J. C. and J. V. Winans of Madison, O., were called, and the midwife retired from the case. The condition of the patient was so alarming that Dr. Winans immediately summoned Drs. A. L. Gardner and L. H. Tillotson of Painesville, O. It was supposed that large doses of ergot had been given by the midwife. I was summoned by telegraph, and arrived at two in the morning, and found the patient in a state of collapse with suspicious symptoms of a ruptured uterus and a non-viable child. Sectio Cæsarea was determined upon, and performed by the light of a kerosene lamp. The uterus was found longitudinally ruptured at the lower third anteriorly, the amniotic fluid escaping into the abdominal cavity, but the membranes, placenta, and child were in utero. Perhaps from the weakened condition of the patient at the time of the rupture, and the syncope following the escape of fluid into the abdominal cavity, all uterine contractions had ceased. No doubt if the labor pains had been severe the contents of the uterus, or the greater part, would have been found in the abdominal cavity.

The operation was in every way similar to Case I., with this difference, that the rupture, which was slightly to the right of the median line, was enlarged, the torn edges were trimmed, and the uterus closed by two sets of animal sutures, the deep suture going to the mucosa, and the superficial approximating the peritoneal borders. The surroundings were unfavorable for successful operation—the woman was moribund, the thirteen-pound fetus dead, and the nursing incompetent. The patient lived but a few hours.

CASE III. Porro's operation. Mrs. W. N. K., a German, æt. forty-three, living in Akron, O., and mother of two

living children. Dr. O. D. Childs had attended her in previous labors. No uterine examination had been made by Dr. Childs since the birth of her last child till the beginning of the third labor. Upon examination he found a very large intra-mural fibroma situated at the junction of the neck with the body of the womb. Consultants were called, and every effort made to deliver by forceps or by turning the child, or by changing the position of the woman, but no advancement was made. The membranes had ruptured eighteen hours after labor set in. I was summoned by telegraph, and arrived forty-eight hours after labor set in. Dr. Childs says the child had been dead three days. The condition of the woman was not very good. I made every reasonable effort to deliver and failed. Could not get even an entrance to the womb owing to the displacement of the os upward and behind the symphysis pubes, as well as from the undilatable os from the fibrinous deposit. Porro's operation was performed, in all respects similar to Case I., with the difference that after the babe and placenta were extracted the neck of the womb was clamped with Keith's clamps, the uterus with the fibroma and adnexa were removed, and the stump dressed extra-peritoneal. The fibroma weighed  $11\frac{1}{2}$  pounds and the child 11 pounds. On the tenth day after the operation there was profuse hemorrhage of the stump, and before the physician arrived the woman was in a state of collapse and shortly died. If the patient had been in the hospital the hemorrhage might have been stopped. If the rubber ligature, since introduced, had then been used the result might have been different.

CASE IV. Ectopic gestation in many respects similar to *sectio Cæsarea*. Miss H., an American sewing girl, æt. twenty-two, a patient of Dr. I. F. Baughman of Akron, O., after a railroad accident first noticed a lump in the right ovarian region. Action was brought against the railroad company, who settled the claim without litigation. The

tumor continued to grow. Fifteen months after the railroad accident and seventeen months after the cessation of the menses, with the assistance of Drs. Baughman, O. D. Childs, J. W. Rockwell, Wm. Murdock, and R. B. Carter, cœliotomy was performed at the rooms of the patient. She refused to go to a hospital. The tumor, which filled the abdominal cavity, was adhered to the parietal peritoneum and abdominal viscera. The incision was in the median line of the abdomen. It required very careful dissection to avoid the intestines, which were closely adherent to the entire circumference of the uterus; the walls of the sac were thick, and resembled uterine tissue. Within the cavity was a dead fetus, which was removed from its placental nidus. The extensive adhesions of the cyst were not disturbed, but the edges were stitched to the abdominal opening. Glass draining tubes were placed both in the abdominal and placental cavities. The child, a boy, weighed eighteen pounds; the nails were so long that they curled around the fingers and toes. Its conception was seventeen months to the time of the operation. The child was in a good state of preservation, but we were not able to elicit any information from the mother as to the exact time of the death of the child. The room, bedding, furniture, and surroundings were very uninviting—in fact everything indicated a picture of squalor; notwithstanding all these conditions the patient slowly recovered, and subsequently married.

CASE V. *Sectio Cæsarea* repeated on same woman as reported in Case I., from Salineville, O., æt. thirty-four, who six years after the first Cæsarean section, became pregnant, making in all her fifth impregnation. At the seventh month of gestation she came to Cleveland for consultation. With Professor J. C. Sanders as consultant, she was advised to return to her home, and in two weeks before the completion of the gestative period she was to enter the hospital and be prepared for the Cæsarean section.



On February 16, 1893, at 3 P. M., two or three weeks before the expected time, while at her home in Salineville, labor began, and at 8 A. M. February 17 they took a train for Cleveland. They came in a day car, seventy-five miles, the pains lasting until her arrival at 7 A. M. By a mistake I did not learn of her arrival on the morning train, and the consultation preceding operative measures occurred at 4.30 P. M. At 5 P. M., twenty-six hours after the rupture of the membrane, I began the operation before the medical class of the college. The method was the same as the first section Cæsarea, following the old line of incision. The old operation had resulted in the adhesion of the entire uterine length to the abdominal wall. The method of suturing the uterus was different, owing to the adhesions of the uterus to the parietal peritoneum; the deep sutures around the tissues included abdominal and uterine walls down to the mucosa, and the superficial sutures merely the abdominal walls down to the peritoneum.

The length of time occupied was twenty-five minutes. The birth of the child was "dry" in this case on account of the early rupture of the waters. The child weighed  $8\frac{1}{4}$  pounds. At the first operation the father positively objected to the removal of the ovaries. It was thought best not to do so at this time, not only on account of most intimate adhesions of the abdominal parietes to the uterus, but from the enfeebled condition of the mother, resulting from labor having continued for thirty hours, and the uncomfortable journey to the hospital during a severe winter night. Professor J. C. Sanders determined the fetal heart beat as 128—prognosticating a boy. The case made a good recovery, despite some bronchitic and erysipelatous symptoms, and returned home in the usual state of bodily vigor. The boy was christened, as a point of remembrance of the method by which rescued, Cæsar, and was a thrifty, well-nourished child.

The doctors present, besides the college seniors, were :

J. C. Sanders, H. Pomeroy, J. K. Sanders, Martha A. Canfield, G. W. Meredith, H. D. Bishop, G. B. Haggart, and Emily Barnes.

*Suggestions.*

Antiseptic thoroughness is essential in every detail, including the care of the abdomen and vagina.

Chloroform is preferable, especially with Junker's improved apparatus.

Ether, in certain conditions, may be safer. If possible prevent vomiting, as it might open the uterine sutures. To prevent vomiting after an anæsthetic have a good movement of the bowels.

Trendelenburg's position is not very desirable in *sectio Cæsarea*.

If the operation is at the election of the surgeon the most suitable time is before the membranes are ruptured, and when the os has dilated in size equal to a silver dollar. Tait's method with a rubber cord around the cervix uteri to stop the hemorrhage, and lifting the uterus outside of the abdomen to extract the child, are of great advantage.

If rubber cord is used beware of secondary hemorrhage. The incisions should be six or eight inches in length, beginning three inches above the pubes, and extending above the umbilicus.

In cutting through the abdominal wall secure all bleeding vessels before incising the uterus.

If the uterus is not lifted out of the abdomen let the assistant press the abdominal walls on each side of the incision down against the uterus, thus retracting the wound edges, and pressing the uterus still prominently into the wound opening.

Before lifting the uterus out insert three or four long sutures of silk through the upper part of the incision, so that the abdomen may be temporarily closed before extracting the child.

Let the incision into the uterus correspond with the abdominal opening, but shorter.

Avoid entering the uterus through the placental site. If the placenta should lie in the line of the incision (placenta prævia Cæsareana) run the fingers between it and the uterine wall, find its margin, and break through the membranes there and grasp the feet and extract as before.

"Do not cut the placental tissue, thus bleeding the child, in placenta prævia Cæsareana."

Deliver by the feet.

If the uterus is not lifted out of the abdomen before the delivery of the child it may be done afterward for the purpose of inserting the stitches.

There are three dangers: shock, hemorrhage, and sepsis.

Hemorrhage may be controlled by manual compression of the uterus or cervix uteri.

Sutures should be thoroughly antiseptic.

Don't use a continuous suture in the uterus.

If the contents of the uterus are septic turn the uterus out of the abdomen before the delivery of the child.

The reason that the uterus was not sutured in the early times was largely due to the persistent existing superstition with regard to the alternating contractions and relaxations of the uterus which forbade the employment of the uterine sutures. Even Porro at one time considered that the contraction of the uterus necessitated its entire removal. Now his operation has been restricted to within narrow limits.

Suturing the uterus largely adds to the good results. Cæsarean section should always be, if possible, elective, not the *dernier ressort*. *Per via naturales* may not always be the best way.

In mismanaged cases Porro's operation is preferable. Fetal mortality is greater in this country, the hospital weight of infants being about 7½ pounds; in private rooms in Europe the average is 6 pounds.

Thanks to the great discovery of the source of the sepsis and its preventive means, this *opprobrium chirurgæ* has to-day assumed, and is destined forever to maintain, its place as one of the benign and most serviceable resources of our art.

Cæsarean section will yield as good results as those now given by cœliotomies.

May we not consider this operation in placenta prævia totalis or even partialis? In placenta prævia marginalis, if the os is rigid from fibrosis, the hemorrhage profuse, the presentation lateral, the cord prolapsed and not reducible, or the fetus evidently suffering, immediate recourse to the Cæsarean section should be had.

If the cord was prolapsed and, after reposition, still descended, the os being partly dilated and not dilatable, dangerous hemorrhage continuing meanwhile, the Cæsarean section would be unquestionably indicated for the safety of both mother and child.

The perforation of the living child is not longer justifiable.

Where there is a viable child is not Cæsarean section *preferable to craniotomy*?

Craniotomy and embryotomy are performed too often. It soon may become a lost art, or it will be relegated to its proper place as an operation on the dead fetus to save the mother, and not to destroy the child.

Craniotomy is a more difficult operation than Cæsarean section.

Dr. Osborn, in the celebrated case of Elizabeth Sherwood, extracted a child through a pelvis measuring three-quarters of an inch in the narrowest portion.

The precise limit at which the dangers from delivery through the pelvis rise to the level of or exceed those from Cæsarean section is not easy to determine. It depends partly upon the size and ossification of the child's head, and largely upon the experience and dexterity of the operator.

The indications of premature labor in pelvic deformities may make the operation justifiable.

Michaelis extracted a small child through a pelvis measuring but  $1\frac{1}{2}$  inch in the conjugate diameter.

From 1777 to 1849, 65 pubeotomies are recorded, saving 44 mothers (32.4 per cent. mortality), and 24 children (64 per cent. mortality).

From 1868 to 1880, 50 operations by three operators saved 40 mothers and 41 children, a mortality of 20 per cent. and 18 per cent. respectively. From 1880 to 1886 Morisana had out of 18 cases only 10 recoveries. But with a perfected technique and by practicing strict antisepsis, better results were obtained, and the last report by Caruso showed in 22 operations 22 recoveries and 20 living children.

From a late report of pubeotomy in 44 cases all the mothers recovered but 1, with a loss of 5 children.

Pubeotomy is on trial; the opinions of specialists differ. Some cases have not resulted well. Schroeder, Fritsch, A. Martin, and Runge treat it with silent contempt. Kehrer, Zweifel, and Winckel condemn. Kehrer writes that it always results in permanent invalidism.

Winckel says: "The good results expected from this operation have not been abandoned, but lacerations of the bladder, injuries to the sacro-iliac joints, and necrosis of the pubic bones have been plentiful."

Pubeotomy not admissible in Roberts or Nagle pelvis.

The so-called Sanger stitch is the best, but be it known to all men that our own Lungren even folded in the peritoneum so as to keep the peritoneal surfaces in contact. He not only did this, but described it in print several years before Sanger, so that everybody could read how he did it.

The Galbiatis knife for pubeotomy.

A ruptured uterus occurs once in 4000 cases.

Hugenberger estimated the mortality from ruptured uterus at 95 per cent.; Carl Braun at 89 per cent.

Spaeth, writing before the conservative operation of Sanger had changed the results of practice, said that there had not been a single case in the Lying-in Hospital in Vienna during the century in which the mother had survived.

Baudon, writing in 1873, said: "In Paris there has not been one successful case in eighty years, though in the present century the operation has been performed on perhaps as many as fifty women."

Leopold says: "The danger to the mother increases directly as the time since the rupture, and the forces used in attempting delivery, those factors leading to exhaustion from hemorrhage or infection. The child dies very soon after the rupture. The mother may show considerable shock within a very short time, but quick assistance and successful control of the hemorrhage can save the woman, and allow a favorable prognosis in the most severe tears, where the woman is seen at once."

Rupture of the uterus anteriorly at the vesico-uterine fold is more frequent than has been generally supposed. A rupture at this point does not necessarily produce severe hemorrhage.

Dr. R. P. Harris reports 9 women whose wombs had been ripped up in advanced pregnancy by the horns of infuriated cattle with the survival of 4 women and 4 children.

"In another report of 6 cases of self-inflicted Cæsarean section, 5 of the women recovered."

In repeated operations shall the incision be through the first? Not unless there are no adhesions.

If the urine must be drawn have the vulvæ, particularly the vestibule and orifice of the urethra, antiseptic.

After Cæsarean section would it not be well to ligate the fallopian tubes for the future safety of the woman, and thus have no repetition of Cæsarean section?

To avoid *post-partum* uterine relaxation operate early.

Vaginal drainage is not always necessary. Consider well before operating upon a dead child.

The Jews, from very ancient times, practiced hysterotomy, now called sectio Cæsarea.

The Greeks were acquainted with the operation of removing the child while the mother was alive, and named it hysterotomia.

The first case recorded with anything like circumstantial minuteness was that done by a sow gelder (Chatner of Seigerheusen) who operated on his own wife.

"Kehrer recommends that the uterus be opened at the level of the internal os by a transverse incision, thus avoiding the placenta and a gaping uterus."

Cohnstein recommended that the whole uterus should be turned out of the adominal wound, and that the opening should be made on its posterior aspect while the aorta is being compressed. He says the tissue is thickest behind, and therefore less likely to gape.

Do not use the utero-parietal suture.

Let an abdominal bandage be worn for months after cœliotomy.

Let the operation be thoroughly and quickly done.

To secure union or healing without pus is the highest attainment of surgery, and counts for more than the brilliant operation.

The operation may be brilliant and skillful, but success depend on the proper preparatory and subsequent care.

Cæsarean section is an easy operation.

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THE CHAIRMAN.—The gentleman who was appointed to lead in this discussion is not present. The discussion therefore will be in the hands of the congress at once, and I hope we may have it discussed. I have the pleasure of introducing to you Dr. Streeter, who will open the discussion.

DR. STREETER.—This is to me a very interesting paper. I am not prepared to discuss it *secundum artem*, but there are some points I desire to emphasize. I am delighted with the record made by our friend, and I think we all have a right to be proud of him. I was also glad to hear that my old friend from Toledo had done such good work in this direction. It seems to me that the Cæsarean section is growing, that the demand for it is growing, and the advisability of it is growing; and just in proportion as the doctors and the people become educated to what seems to be the wisest plan for women *in extremis*, just so soon will they submit to an early operation, and it seems to me it is the early operation that is bound to be successful. Most of these cases except two, which the doctor narrated, were upon women *in extremis*; two of them were premeditated cases. I believe, as he says at the end of his remarks, Cæsarean section is an easy operation. It is an easy operation, but in



a majority of cases the operation is performed when the woman is so far exhausted, so extreme in her debility, that her chances are not at all good. The trouble is not in the operation, but in deferring to a time when the woman does not have a reasonable chance for her life. If we can educate ourselves and our patients to a belief that there is surgical aid in these extreme cases of pelvic deformity, that it is a reasonable safe remedy, just so soon have we done them and ourselves a very great service.

It is only a few years since if a case of Cæsarean section was performed in Europe it was heralded all over the world, and if it was done in this country Europe knew it by telegraph.

Now it is done throughout the world and in the backwoods, and successfully done. It is a wonder too that it is done so successfully, because, as I said before, most of the women are half moribund before the operation is commenced. You would not by preference operate in that way.

Discover these deformities if you can in time, and set the time to operate, and make it a premeditated case, make every preparation for it, and it will be as simple and as satisfactory in its results as laparotomy. I am very much obliged to Dr. Bigger for this careful paper.

CHAIRMAN.—While waiting for another I might interject a word with regard to a double Cæsarean section. This was performed on a woman, and she recovered. A silver suture was used in the uterus.

The doctor told me all about this, so that I speak advisedly. He used the silver wire in the uterine wall, twisting it down and leaving it, and when he came to perform his second operation on the same woman three or four years later he found the silver sutures there in a perfect state, bright and clean. The uterus had gone on in its expansion, and the silver wire had not caused any trouble.

He had to perform this second operation at the peril of

his life, a drunken husband threatening to kill him if she died, and he determined then and there that he would never perform it on her again, so he did what was unknown at that time, and I haven't heard of it having been done anywhere since—he ligated the fallopian tube, and so stopped the business.

DR. PRATT.—It has been a long time since I have delivered babies, but at one time I was doing it at quite a rapid rate. I never killed a child to save a mother. I have been called to deliver them after they were killed, have been called into counsel.

The valuable part of this paper to me lies in the suggestion of preventing craniotomy. It is very rare that we will ever come across that—that there ever occurs a case of rupture of the uterus into the peritoneal cavity at confinement. I have never encountered one in my personal experience, nor have I ever come in contact with a medical gentleman that has reported such a case to me. They are in the books, and Dr. Bigger very kindly furnished us with illustrations of that kind of cases, but they are so rare, and when they do occur the collapse is so extreme, that Cæsarean section simply offers a forlorn hope that is doomed before you touch it, and it is so rare that the report is of no avail to us.

But it is so frequent that children are too large to be born in the natural way, and they have to be killed or die from very prolonged labor, that the practical suggestion of doing Cæsarean section to save the life not only of the mother, but of the child also, is a very valuable part of the paper.

This is the age, I think, of abdominal section; it is the age of going into the abdominal cavity with impunity. I would like to relate one experience which I think would have saved not only the life of the child, but also of the mother, if the doctors had acted upon the knowledge which this paper makes common to us.

I was called to a neighboring town in my earlier surgical career, when I was not as old or as brave or as competent in any particular as I am at present. A woman had been in labor. It was among the poorer classes; it was the very center of squalor. They were an unhappy, quarrelsome family, as well as a half-starved and a half-clothed and a half-frozen family. It was cold weather, and yet they had no fire in the house. The woman had been in labor for a week. She was a hunchback, and had also a distorted pelvis, so much so that it was impossible to get even three fingers as far as the uterus. It happened to be a leg presentation; the feet came down first, and the doctors pulled the child by piecemeal. They got away one leg, and then the other leg, and then the body, and finally the arms, and left in the womb nothing but the head itself. The woman had been trying to deliver that head when I saw her for one week, and they asked me to come and perform Cæsarean section. I went out there prepared for Cæsarean section, at the same time having confidence that by hook or by crook I could get the remains of that child out of the pelvic cavity.

I went with all the instruments at my command, but was unable to strike the head with any instrument with me, so I was compelled to do Cæsarean section. I performed it in the midst of that dirt and squalor and the uncomfortable surroundings to the best of my ability. It was not an antiseptic operation. The conditions were not favorable to it. What surprised me at that time was the thickness of the walls of the uterus. I expected to find a tissue paper wall, thin and wasted away. Instead of that the walls of the uterine cavity were fully two inches thick.

I opened the walls and removed the head and afterbirth, and the blood, which gushed very rapidly at first as I went through the uterine walls, stopped itself under the uterine contractions. I had no difficulty in checking the hemorrhage. I stitched the uterus and the abdomen, and left the

patient in the care of an exceedingly incompetent nurse. I am satisfied now that if I had taken the precaution to take a nurse with me I would have saved the woman. She lived one week without any fever or chills, or any trouble whatever, but at the end of the week there occurred a family row, and she got out of bed to take a hand in it. The result was she died in forty-eight hours.

DR. LUDLAM of Chicago.—Concerning a case which I reported a little while ago, I suppose that many have read the report and are familiar with the case which I had the honor to conduct. The chairman of the bureau has requested me to give the details of the case, and therefore I will repeat myself with your permission.

I might say, by way of premise, that so far as I know my case is the only one that has ever been made in this country because of uterine fibroid.

Briefly, the case was one of pelvic obstruction by a fibroid which lay below the child, and which twisted the cervix out of place so it never came down, and was not accessible in any way, shape, or manner from below. Another peculiarity of the case was as soon as we discovered the fibroid within the pelvis we also discovered, or had evidence to believe, that the patient was pregnant and about the fourth month. The diagnosis, however, could not be absolute. I recommended under the circumstances the making of an exploratory incision, so that the complicated conditions might be plain, and it might appear then as to what would be best—whether to remove the fetus, to remove the uterus I mean, by way of Penn's operation, taking the tumor along with it or not, or to leave it until the full term.

So at the fourth month, as I recollect, we made an exploratory incision through the abdomen, as usual, and came down to the pregnant uterus, lying off on the right side. The appearance of the uterus, the thickness of the wall of the uterus, made us feel (though we did not touch it much, I assure you) that the patient was pregnant.

The fibroid could be felt below the brim of the pelvis. It was therefore deemed practically impossible or impracticable that the labor should be consummated under the circumstances ; but I said, with plenty of space for this uterus to develop, with a good position of the organ, with the fact that this tumor does not involve its capacity at all, why not let it go on to term ?

A reason, and a very weighty one too, under the circumstances, was that the couple were very desirous to become parents. The prospective father and mother were happy with the idea of having a child, and determined if any means could secure that end those were the means they desired.

So with this backing, with the understanding that the incision was exploratory, the wound was closed, and we decided to await events. I am sure that during the next, the last half of the period of gestation we were all quite anxious as to the outcome of this case.

We recommended exercise in the open air, plenty of good food, and all that sort of thing ; and in the most natural way she rode about the country and had a good time until term, and then we were to be notified directly there was any appearance of the signs of labor. I remember very well one evening coming home from one of my lectures with my assistant, and finding a call to go forty miles into the country by the very first train. We had less than an hour's time to pack up our duds and get to the train. We reached the place about one o'clock in the morning, and went to this little private hospital and got ready to look the case over.

The waters had been discharged ; the cervix could not be felt or found at all ; the pain had subsided with the discharge of the water. We had a consultation with Dr. Clark, who was looking after the patient, and was to assist us in the matter, and very kindly did. We resolved at my suggestion that we would not wait until daylight lest the pains should come on and constitute an obstacle.

We made a window in that uterus and got the little rascal safely out of that window—safely for himself, as it turned out, and for the mother. We went at it at two o'clock in the morning, under gaslight, and I should like to have had a photograph of the scene. Not for any advertising purposes—God forbid—but as a sort of reminiscence of the way the thing was done. We made an incision of twelve inches over the abdomen, and an eight inch incision through the uterus, came down upon the membranes, and went through them very gently and quickly, for there was no time to waste or time to discuss, and no talk. I had instructed my assistant, Dr. Stetler, who was on hand, and in a lively way too, I assure you, to tie that cord, if they ever got at it and the youngster was alive, as quickly as possible. The cord was tied after a manner that I recommend in emergencies and haste when you want delivery.

He snapped the two forceps across the cord. They were gauged forceps. He snapped one here and one there, and a pair of scissors went between, and a great deal quicker than I can tell it the baby was off to be resuscitated. When the baby cried, which was while we were delivering the afterbirth, we heard the sound, which was music to us and to the new mother. The short of it is that the mother made a prompt and excellent recovery. The child weighed eight pounds, and I suppose is going to Sunday school now.

DR. BIGGER.—In regard to the previous report I would say in a ruptured uterus it was the first I knew anything about, and the suspicion of it was the syncope. Some writer has said, and it is embodied in a paper, that a ruptured uterus occurs once in four thousand times. This is from the Vienna report. I do not know that it is found as often as that. It is merely a statistic that is given. But another writer says that a rupture of the uterus occurs with a proper delivery of the child more frequently than is known by the obstetrician.

## UTERINE FIBROIDS.

BY

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THE non-malignant neoplasms of the uterus are classed under the general name of fibro-myoma. This compound word covers, at least, two distinct classes, the fibroid or connective tissue tumor and the myoma or muscular tissue tumor. They differ in gross and minute anatomy. The connective tissue tumor is *in* the uterus but not *of* the uterus. It has a well-defined, though loose capsule, from which it can be shelled out without serious deformity to the organ in which it is found. It is slow of growth; never appears before puberty or after the menopause; rarely *increases* after the menopause; causes hemorrhage, at times, and pressure symptoms, but does not often give constitutional symptoms and is seldom the immediate cause of death.

The myoma is chiefly hypertrophied muscular tissue. It is in the womb and of the womb. It has no capsule of any kind, but gradually shades off into healthy tissue. It is usually found at the fundus, but it often involves a large portion of the organ. It cannot be removed without seriously mutilating the uterus. It grows rapidly; gives constitutional symptoms, as well as hemorrhages, and it is frequently the subject of degenerative changes, either cystic or myxomatous.

The fibroid is much more common than the myoma and it alone is taken as the subject of this paper. As the chief interest in all morbid growths hinges on the treatment, I shall have but little to say in regard to its pathology, etiology, or symptomology.

All fibroids of the uterus begin their lives within the

the muscular wall of this organ. They remain interstitial or intra-mural, or they grow in the direction of least resistance, and finally become either sub-peritoneal or sub-mucous. The accidental development gives rise to the three varieties under which these tumors are classed. But whether interstitial, sub-peritoneal, or sub-mucous, the tumor always presents the same general characteristics. It is a connective tissue tumor—firm, hard, somewhat elastic, pale in color, cuts like cartilage, and its cut surface shows concentric layers of connective tissue arranged around one or more centers. It grows after the manner of exogenous plants by appropriating layer after layer of the loose connective tissue bark, which we call its capsule. It receives its blood supply from the large vessels which ramify in this capsule. Few vessels and no nerves penetrate the substance of the tumor. More than ninety per cent. of these tumors show themselves between the ages of twenty-five and forty-five. In clinical interest these tumors increase in importance from without inward, the sub-peritoneal ones being of least importance. Situated under the covering membrane of the uterus, they have a strong tendency to become pedunculated and retain but a slender hold upon that organ. They do not, as a rule, greatly increase the size of that organ, do not often cause an increase of the menstrual discharge, and are only troublesome on account of pressure symptoms. Indeed, they sometimes sever connection with the parent organ and form other attachments or remain free in the abdomen; nature, in these cases, giving the hint to the surgeon as to the best method of treating pedunculated sub-peritoneal tumors if they become burdensome.

This variety seems to be but little affected by either medical or galvanic treatment. If the patient cannot tolerate the growth there is but one remedy, and that the knife.

The intra-mural tumor gives more marked symptoms.



The uterus is enlarged in exact ratio with the size of the tumor; the mucous lining is increased in area, thickened, softened, and made more vascular. This gives rise to the menorrhagia which is such a frequent symptom. These cases do not often give sudden and profuse hemorrhages, as do the sub-mucous ones, but the bloody discharge is so continuous as to be a serious drain upon the woman. Add to this the pressure upon rectum or bladder, or both, and we find a combination which is distressing. Medicinal treatment and galvanism promise more in these cases than in the former, but still they do not show very satisfactory results. It is the *sub-mucous* tumor which gives rise to the most distressing and serious symptoms, and it is, therefore, of the greatest clinical interest. Fortunately, this variety gives us the widest latitude in means of relief, and in most respects the most satisfactory results.

We will for a moment consider the *cause* of the symptoms which the sub-mucous tumor produces. The symptoms of sub-mucous fibroids are such as would be caused by a foreign body in the uterine cavity. Nature's effort to force this body, first into the cavity of the womb and then expel it entirely, gives rise to pain from unconscious contractions, irregular discharges of mucus and blood from the whole lining membrane, and occasional profuse hemorrhages from ruptured vessels or sinuses in the capsule. The effort of nature to pedunculate these growths and then expel them gives the surgeon a useful hint as to treatment. A moderate percentage of these tumors would be disposed of by unaided nature if it were safe to wait. Pedunculation, with gradual wasting of the pedicle, ulceration of mucous covering and capsule, with enucleation *in toto*, or the breaking down of the tumor and its discharge in offensive fragments are not uncommon, and some women pass through the ordeal in safety. But the dangers from hemorrhage, and especially from sepsis, make the careful surgeon unwilling to trust to unaided nature, and they

force him to do in an aseptic and rapid manner much the same things that nature is trying to do in her slow poisonous way.

Now as to treatment: First, what medicines may be expected to act upon these neoplasms, either directly or by diminishing the blood supply to the capsule. Almost every remedy in our materia medica may be called upon to cover direct or intercurrent symptoms, but very few have any control over the tumor itself. The medicines which have been the most used are, first, the bromides—which are fast going out of use. They were used long and indiscriminately, but with little effect.

Second, the iodide of lime in matutinal doses, in the hope that the deposit of the lime in the capsule would cut off the blood supply and change the growing tumor into the quiescent “womb-stone.” There are a few cases in which this remedy seems to have done some good.

Third, hydrastis can. is coming into rather frequent use to moderate the hemorrhages and for a supposed specific action upon the tumor.

Fourth, ergot. This remedy has made many advocates and is still in frequent use. It acts in two ways: first, through its influences on the muscular coats of the arteries it diminishes their caliber, and second, by exciting muscular contraction in the uterus it cuts off the blood supply or favors expulsion of the tumor. In well selected cases ergot will prove a useful adjuvant, but it should not be depended upon in *any* case, and is absolutely useless in most.

In the sub-peritoneal variety it is worse than useless; in the interstitial it is of doubtful benefit; but in the sub-mucous tumor it may, if wisely used, aid in the enucleation or the pedunculation of the growth. Thus much for the specific medication of fibroids—it is not to be relied upon. I will not speak of the symptomatic medicinal treatment, for that would involve the naming of half of our materia

medica. Well selected remedies will *relieve* the urgent symptoms, but they rarely, if ever, cure the fibroid.

Electricity holds a prominent place in the treatment of these growths. So prominent has it become since Apostoli formulated and published his methods that, in the opinion of many gynecologists, no case should be operated upon until it has first been thoroughly treated by the galvanic current. My investigation and observation teaches me that at least fifty per cent. of sub-peritoneal and intra-mural tumors are benefited by galvanism, and some of them are cured. The common result in favorable cases is moderate shrinking of the tumor and a marked diminution in the symptoms due to pressure or congestion.

In the sub-mucous tumor the chances of permanent improvement are not so good. The positive pole will check the hemorrhage for a time, but it is apt to return. In some cases it is the best treatment short of enucleation. The only great change which has come since Apostoli formulated his views is the disuse of the needle and actual puncture. Equally good results are obtained with the intra-uterine electrode, without the dangers which must attend puncture. The almost universal rule is to use the large abdominal pad with the positive pole and a small intra-uterine electrode attached to the negative pole in all cases not complicated by hemorrhage. In the bleeding cases the poles are reversed. A servicable current is from seventy-five to two hundred and fifty milliamperes continued from four to twelve minutes, and repeated from two to six times per week, as the case can bear it. Treatment should be followed three weeks in each month for three or four months.

The surgical measures for the palliation of symptoms are, first, ligation of uterine arteries through the lateral fornices, second, the removal of the ovaries and tubes. These measures are warranted in hemorrhagic cases in which for various reasons radical measures are contra-indicated.

Ligation of the uterine arteries is simple, easily done, and unattended by danger. As the chief blood supply is through these vessels we have reason to expect a marked decrease in the hemorrhages. The removal of the appendages operates in two ways. It diminishes the blood supply (by the ligation of the ovarian arteries) and it produces an artificial menopause and relieves the woman from the periodical congestion which attends her menstrual life. The production of this artificial menopause has given excellent results, as a rule. The tumors cease from troubling and often decrease in size. A combination of the two methods ought to be safe and very successful.

First ligate the uterine arteries and two weeks later remove the ovaries and tubes. The blood supply would then be practically inhibited and the tumor must grow less. I have done these operations in one case with the most gratifying result. The tumor was reduced at least fifty per cent. in one year, and the woman lost all consciousness of it.

In speaking of radical surgical treatment of uterine fibroids, we must divide the subject into two classes, those in which the tumor can be removed per vaginam, and those in which it is necessary to open the abdomen. The first class should include only *pedunculated* sub-mucous tumors. The exception to this rule would be an occasional broad based or sessile sub-mucous tumor. The enucleation of intra-mural fibroids per vaginam is a more serious operation than abdominal extirpation of the uterus, and should not be attempted unless under very exceptional conditions. The pedunculated fibroid is nothing more than a fibrous polypus, and it can be treated as such. The cervix is to be widely dilated, the tumor seized with a strong volsellum and dragged down through the dilated cervix until its pedicle can be reached. The mucous covering of the pedicle should now be cut through and the pedicle "shelled" away from the uterine wall by the finger nail or some

blunt instrument. This insures the total extirpation of the growth.

Little after treatment is required. In the case of a sessile tumor, wide dilatation of the cervix is to be followed by a longitudinal incision through the mucous covering and the loose capsule of the growth. The membrane and capsule are to be stripped back, right and left, until the lower portion of the hard mass can be grasped by strong volsellum forceps. Now, steady and persistent traction is to be made by an assistant, while the operator with fingers, blunt scissors, or such other blunt instruments as he may find useful, strives to loosen the tumor from its capsular bed. There will be some smart spurts of blood, but these will not last long, for the uterus is thrown into contractions by the traction on the tumor and we now have a *vis a tergo* to help expel this foreign body. The operation is a protracted one, and the patient need not be kept profoundly anæsthetized. She should be watched carefully, stimulated if necessary, and occasionally the operation will have to be suspended for twenty-four hours to give her time to pick up. If this is the case, the vagina and uterine cavity should be left in an absolute aseptic condition and thoroughly packed with iodoform gauze. Usually one long sitting will suffice, and the tumor will gradually yield to traction and enucleation. No one should undertake the enucleation of a broad based fibroid without being prepared to do total extirpation if by failure or by accident this should become necessary.

The second class includes all interstitial and sub-peritoneal cases which require surgical interference. During the past few years "fibromectomy" (or, as the Germans say, "myomectomy") has been by experiment and improved technique put upon a comparatively safe footing. The great mortality which followed it, even in the most skillful hands, has been so reduced that it now compares favorably with abdominal section for other causes.

In most cases where fibromectomy is indicated it is impossible to determine what the exact operation shall be until the abdomen is open. The variety, size, position, and relations of the tumor have to be considered, and also the age and the social and domestic condition of the patient. In some cases it is of the utmost importance to leave the uterus unmutilated, that the woman may possibly bear children; in other cases this is a matter of no consequence and the easiest and safest way may be adopted. If the tumor is a subserous one and distinctly pedunculated, the pedicle may be ligated after the manner of an ovarian cyst-pedicle. The stump should be cut V shaped and carefully sutured. If the tumor is interstitial and small, the uterus may be split wide open antero-posteriorly and the tumor shelled out, the uterine walls being drawn again together by layer after layer of buried catgut sutures, strengthened on the peritoneal surface by a few deep silk ones.

Sessile, sub-peritoneal, and interstitial tumors when large can only be removed by hysterectomy, either supra-vaginal or total. It is not necessary to go into the details of the various methods in which this operation has been done. All have had their advocates and most of them some merit. The problem of the pedicle has been the hard one to solve. Whether it should be treated extra-peritoneally or dropped back like the stump of an ovarian cyst was the point of contention between abdominal surgeons. There is but little doubt but that the extra-peritoneal advocates could show the best results, even when their only method was to fix the stump in the lower angle of the wound either with clamp or elastic ligatures and skewers.

Martin's method of total extirpation settled the question of stump so far as his cases are concerned, and it gives good drainage; but it increases the mutilation, the vagina being often impaired. The two methods for the extra-peritoneal management of the stump have been presented within the last three years, one by Dr. Henry T. Byford

of Chicago, and the other by B. F. Baer of Philadelphia. Byford's plan is to cut and tear through the anterior vaginal wall, in an ingenious way, an opening large enough to admit the stump, which is to be bent forward and forced through it. The stump is now clamped from within the vagina and allowed to slough. This is unquestionably a great improvement over the old methods, but it lacks in simplicity. It has proved very successful in the skilled hands of its author.

The method of Dr. B. F. Baer of Philadelphia is simplicity itself, and it commends itself for several reasons; it is easily done, the stump is not ligated and, therefore, will not slough, it is left extra-peritoneal, there is no traction upon it, and there is no mutilation of the vagina.

The peculiarities of Baer's operation, ligation of ovarian arteries, cutting loose the upper part of the broad ligament, stripping down the peritoneum from a little above the os internum in front and behind, the ligation of the uterine arteries, either through the ligament or within its folds, the amputation of the neck so as to remove the entire supra-vaginal portion, the stump dropping deeply into the pelvis and being completely hidden by the raw flaps of peritoneum, and the stitching together of these flaps by Lembert sutures. The cervix is now in its normal position as regards the vagina and is entirely extra-peritoneal. It has no ligature or suture in its tissue and it is covered by raw peritoneum, which will immediately adhere to it.

If, in addition, the cervical canal is widely dilated before it is dropped, it will furnish complete self drainage in the event of an extra-peritoneal abscess, as was the fact in one of my cases. It seems to me that this is the simplest method of abdominal hysterectomy and the one which promises the best results. It treats the stump extra-peritoneally, without tension and without slough, and it leaves the vagina un mutilated. It is not necessary to add that

in all these surgical methods the most perfect aseptic precautions are of the utmost importance.

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### VAGINAL HYSTERECTOMY.

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BY

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THIS operation was introduced as a cure for carcinoma uteri, but it may frequently be called for in non-malignant diseases, as prolapsus, intractable inversion, neurasthenia, accumulation of pus about the uterus (which cannot safely be reached by abdominal section), extensive laceration, and myoma with protracted hemorrhage, or pain not amenable to other treatment. Such well-known surgeons as Billroth, Schede, Schroeder, Martin, Olshausen, Fritsche, Kaltenbach, Gusserow, Leopold, and others have placed on record several hundred operations with a combined mortality of about fifteen per cent.; and a half dozen individual operators, with series of cases varying in number from thirty-five to eighty, have reduced the mortality to five per cent. This brings the percentage of recoveries down to that of ovariectomy, and is a marvelous record. But we must bear in mind that the primary results are not the most satisfactory or important; the operation is of too serious a nature to be adopted as a palliative; it should be employed as a curative measure only. Olshausen, Shanta, and Fritsche\* have each had 47.5 of their patients perfectly free from recurrence after the lapse of two years. Martin† had, out of 58 patients, 34 free from recurrence after more than three years; out of 52 patients, 25 free from recurrence after four years; out of 30 cases, 18 after five years; out of 9, 6 after six years and out of 2, 2 after seven years.

\* *Annals of Gynecology* for November, 1892, p. 78.

† *American Journal of Obstetrics* for October, 1892, p. 535.



This is a combined average of 70.3 per cent. of his patients, who were perfectly well after the lapse of five years.

In order to secure these results, the cases must be selected with great care. If the disease has involved the bladder, vagina, rectum, or broad ligaments to such an extent that the uterus is not movable, on account of carcinomatous deposit or adhesions, or so that every particle of the disease cannot be extirpated, this operation should not be considered. However, fixation from inflammatory adhesions is not a contra-indication for vaginal hysterectomy. Unfortunately for humanity, these indications render unfit for operation at least three-fourths of the patients who present themselves for treatment. This is due to the absence of treatment in the beginning of the disease, the obstacles to an early diagnosis, and faulty teaching.

There are four symptoms which were laid down by the older authors, and regarded as pathognomonic of carcinoma uteri, *i. e.*, pain, fetid discharge, hemorrhage, and cachexia. Now these are extreme "danger signals"; when they are present it would be a miracle if a single patient could be cured, and to wait for them is murderous. As every physician knows, the cervix uteri is not very sensitive, and pain does not develop sufficiently to attract attention until the internal os is reached and the greater portion of the cervix is destroyed. Then the uterine nerves and vessels are involved by carcinomatous proliferation, there is hemorrhage, the discharge decomposes and is fetid, of course, or is absorbed, there is septicemia, all of which develop the cancerous cachexia. The laity, even, readily diagnose the disease when these symptoms are present, and many physicians wait for them, although modern surgeons everywhere oppose such practice.

This careless, negligent, and unscientific treatment, or lack of treatment, must be given up, and with it that other untruthful and inhuman doctrine, that nothing can be done to save these patients, heroic and trustful women. In pro-

portion as we do this will we increase the number of operable and curable cases, and correspondingly lessen the great majority, whose disease has been allowed to reach a point where we can only scrape out the sloughing tissue, and disinfect the parts. At present three-quarters of the patients come to us at this advanced stage of the disease, and I believe the fact is largely due to the above faulty teaching, which still lingers with the profession.

The symptoms of corporeal carcinoma in the beginning, like those present when it is in the cervix, are not numerous or marked, and the inability to see or feel the disease augments the difficulty of the diagnosis. It appears to be more frequent in the nulliparæ, or women who have borne few children, and have not sustained cervical laceration. The attention of the patient or physician is usually attracted, as in disease of the cervix, by occurrence of hemorrhage or discharge, which, unlike carcinoma of the portio, may be attended by colicky pains. Bimanual examination does not afford much, if any, information until the disease is far advanced. But the true nature of the malady may be made out by dilatation of the cervix and the removal of tissue from the mucosa for microscopical examination, the same as in the diagnosis of cancer of the cervix. In this site the disease usually develops in women who are free from hereditary tendencies to carcinoma, and have sustained lacerations of the cervix uteri in child-bearing. The rent fails to heal; it is irritated by frequent coition; by parturition; by every move of the body; and finally epithelioma develops from irritation, just as on the lip in inveterate smokers of the clay pipe. Now the most important feature in the treatment of the disease is to recognize it on the start, when it is a purely local affection and amenable to treatment.

Its early presence may be discovered by inspection; The infiltrated portion is often of a yellowish hue, somewhat elevated and sharply limited. If the disease be car-

cinomatous, bits of tissue may be easily dislodged by the finger nail; and where the growth has moderately developed, the information imparted to the educated touch is scarcely inferior to that of the microscope. In women from thirty-five years of age and upward, every unusual leucorrhea, watery discharge, spotting, staining of clothing after coitus, menstrual irregularity, or hemorrhage, should always lead the physician to be on the alert, lest the above symptoms be misinterpreted, and the case go on to an inoperable stage before the true condition of affairs be apprehended.

There is a popular belief among the laity and physicians, handed down from our fathers, that it is not usual to have hemorrhage, spotting, or other irregularities at the menopause, as a normal condition. This notion must be corrected. It is not true, and it causes untold suffering and and the loss of scores of valuable lives. When these symptoms develop, there are always good pathological reasons for their appearance; the diagnosis of fibroma, adenoma, sarcoma, or carcinoma, of the uterus usually explain them, and enable the attendant to apply the appropriate surgical treatment, and thus escape the disapprobation which always follows careless treatment.

When this has been done, he may use the similitum, if he desires. It is unpardonable negligence to allow carcinoma uteri to advance too far, and the poor patient to be doomed before radical treatment is even advised. No physician should attend a patient, especially at the menopause, who has "spotting," hemorrhage, or a watery discharge, without insisting upon a vaginal examination, the use of the sharp curette, or the removal of a wedge-shaped piece from the cervix uteri for microscopical examination, if necessary. Should the patient decline these all important diagnostic methods, or radical treatment, the only way to escape condemnation is to abandon the case. If the family physician does not take this course, the surgeon

may shield him faithfully and conscientiously, yet the friends will ever after censure that physician, and very justly so, too.

In the preparatory treatment most operators consume from three to six days. This is not only unnecessary but positively harmful. Patients grow very nervous after they enter the hospital with the expectation of an operation; and a long and tedious course of dieting, scrubbing, and douching unsettles and depresses them. I do not favor curetting as a preparatory treatment. It subjects the patient to unnecessary operations, with loss of blood and strength; it opens the vessels and may give rise to sepsis or cancerous infection. While I know that the success of every operation depends upon the most careful preparation, yet I believe that eighteen hours is sufficient time for any surgeon to place his patient in the best condition of surgical cleanliness, and thorough preparation for the anæsthetic. My patients do not usually go in the hospital until the night before the operation is to be performed; then they have a general bath, a carbolized douche, 1-80 or a bichloride, 1-1000; a clean bed and night clothing. The next morning a bath and a copious douche is given, and at seven o'clock a cup of beef tea only is allowed. The external genitalia are carefully shaved and scrubbed with soap and water. At ten o'clock she is anæsthetized, brought into the operating room, placed in the lithotomy position, and the parts are again scrubbed and washed with soap and water. The bichloride or carbolic douche is directed on the parts, and the vagina is for the second time thoroughly irrigated and washed out by the finger.

The clamp operation is extremely simple: The patient is brought down on the end of the table and is secured in position by any convenient gynepod, or held by assistants. With a strong, blunt pair of scissors the mucous membrane is divided around the cervix uteri, taking care to keep at

least one-half inch from the diseased tissue, and not to enter the bladder or rectum. The flap of vaginal tissue if it be found necessary to go out so far, is dissected down to the cervix, and the connective tissue between the rectum and bladder divided, chiefly by the fingers and thumb nail. In most cases, after the circular incision is made, cutting instruments are not used until the broad ligaments are divided, and not a single vessel requires the ligature. In a few instances, however, while separating the bladder or rectum, bands of strong cellular tissue must be divided by the scissors before the dissection can progress.

The pelvic cavity is opened either before or behind the cervix, just as is convenient, and the peritoneum torn from the uterus back to the broad ligaments on both sides.

On account of the stretching of the peritoneum before the fingers I have sometimes found it necessary to puncture it with a slender pair of uterine dilators, expand the blades, and thus make an opening for my finger. When a good hold is obtained it is not usually difficult to tear the peritoneum back to the broad ligament on each side. Now the organ is free from all attachments except the broad ligaments, and the clamps may be applied without difficulty. If, however, the vagina is long and narrow, and the uterus above the average size, the case is very different. In such a condition the soft cancerous granulations must be scraped away, the cervix packed with gauze, and sewed up to prevent infection: then the uterus should be inverted. This affords a great advantage, as it brings the fundus down where the ligaments are within easy reach, so that they can be readily tied by the progressive ligature, or clamped. If these instruments be applied, the sliding knives with which they are provided may be pushed home, and the uterus cut away. This knife attachment is an important feature of the clamps, as in large uteri or small vaginæ it is both difficult and dangerous to cut the uterus away with the scissors.

Another desirable feature of the clamps, as modified by me, is the peculiar and simple hook-lock. The female blade is first introduced under the ligament, and may be used as a blunt hook to draw the part into view, so that the male blade of the clamps can be applied over the ligament, by sight. In some cases the ligament cannot be drawn down sufficiently, and we are obliged to adjust the instrument by sense of touch; if this be impossible, it can usually be locked without even this aid.

Next, the bladder is sufficiently distended to be sure that the organ has not been wounded. The rectum is also inspected. If there are bleeding points they are tied. A strip of gauze is carried up between the clamps to promote drainage, and the vagina protected from pressure by packing gauze between the soft parts and the clamps. Even when this precaution is taken there is usually superficial sloughing of the vaginal mucosa, but it does no harm.

The after-treatment is conducted in precisely the same manner as after abdominal operations. No food is given by the mouth for two full days. A little liquid may be used to moisten the lips. The thirst can be overcome by the use of hot water enemas, of twelve ounces each, every four to six hours.

If there has been considerable loss of blood, forty-five grains of sodium chloride and fifteen grains of sodium bicarbonate are added to the enemas. If shock is present, an ounce of brandy may also be included. The patient is kept on her back for the first two or three days, and gaseous accumulations are relieved by copious enemas of soap and water; or it may occasionally be necessary to add turpentine emulsion before the bowels can be moved. The urine is drawn, or conducted away from the dressings by means of an instrument shaped like a shoe horn. The dressings are changed at the end of the first twenty-four hours, or when necessary, except the gauze about the clamps; this is removed with these instruments at the end

of forty-eight hours. If an effort is made to remove the clamps sooner, there is danger of hemorrhage. In three out of a dozen cases in which I removed them at the end of twenty-four to thirty-six hours, I was obliged to take the patients into the operating room to check the hemorrhage, which nearly caused loss of their lives. But I have never seen a case of hemorrhage follow removal of the clamps after forty-eight hours. Boro-glyceride is the best application to use, as it depletes the somewhat inflamed tissues, and keeps the parts supple. It is smeared over the external genitalia, and introduced into the vagina by the fingers. If there is much discharge, or, especially, fetor, a carbolyzed douche is used, and the external genitalia washed twice a day, or often enough to insure cleanliness. Patients are allowed to get out of bed on the sixteenth day, and to leave the hospital in about three weeks.

The clampoperation is more quickly performed, is attended by much less shock, and secures the vessels with greater certainty than the ligature. Again, the technique is more simple; the instruments and appliances actually needed for this method of performing vaginal hysterectomy are: irrigator, sterilized water, Sims' speculum volsella, blunt scissors curved on the flat, artery forceps No. 26 (F), conical sound, No. 1 catgut ligatures, dressings, and a catheter with which to test the bladder. This outfit is sufficient in most cases, yet in complicated ones the surgeon should have at hand, besides the above, different sizes of catgut and silk, a scalpel, and aneurism needle. It is my practice never to prepare for a simple case, but secure everything that could possibly be needed under any circumstances.

The operation by means of the progressive ligature, as it is designated, has serious objections; the greatest of which is the fatal shock due to greater traumatism, and length of time consumed with the complicated technique. If catgut be employed, except by those accustomed to its preparation or use, there is danger that it will slip, or absorb too

quickly and give rise to secondary hemorrhage; silk, if cut short, may remain as a foreign body, keep up a discharge, and make it necessary to annoy the patient by a second operation to extract it. If this material be tied down and the ends allowed to protrude from the wound, there is danger of sepsis from capillary attraction, and the silk threads cannot often be removed before the fourteenth week. Where the clamps are employed, they come off within the first forty-eight hours, there is but little danger of hemorrhage, and the patients are discharged from the hospital within three weeks. Then, the clamps can be applied much higher than ligatures, even if the vagina be stretched or incised. The objection that the clamp operation is unsurgical, or not an ideal operation, goes for nothing, since better results have been obtained from them than from the ligature.

For the past six years I have practiced according to the foregoing principles with success, which has been satisfactory to myself, and a source of great benefit to my patient. During this time I have removed the uterus per vaginam forty-two times. Many of these operations were easy, and required but a few minutes; others were complicated, attended by accidents, and demanded all the skill I could command. The shortest operation consumed but eight minutes, and the lady was out of her bed only a quarter of an hour. Three took from forty-five minutes to an hour and one two and a half hours,\* the remainder were easily finished within thirty minutes. The complications which prolonged the operations were: hematocele, extension of the carcinoma to the broad ligaments, † very large uteri or small vaginæ, destruction of the cervix, and inflammatory adhesions.

The operations were for the following diseases: 2 for prolapsus uteri (1 of which was complicated by carci-

\* Recovered without complications.

† One case.



noma of the portio); 2 for neurasthenia; 1 for a complete unilateral laceration of the uterus, with an incurable purulent discharge; 1 for malignant adenoma; 2 each for sarcoma and carcinoma of the fundus uteri. In the remainder, 32 cases, the cancerous disease started in the portio or cervical canal.

Two patients died, and the causes of their deaths were determined by *post-mortem* examinations. The first was sent by Dr. D. McPherson of Palmyra, N. Y. Death was from septic peritonitis caused by a cancerous nodule (three-quarters of an inch in diameter) which was detached during the operation and lodged in the pelvis near the origin of the left broad ligament. The uterus was five inches long, and correspondingly thickened. The operation was exceedingly difficult. The second death was a patient from Dr. W. M. Follet of Seneca Falls, N. Y., and was caused by ileus. I opened the abdomen and broke up the adhesions which obstructed the intestine, but she did not have sufficient strength to undergo the second operation and died on the seventh day. Her uterus was four and a half inches long, and the operation was also very difficult.

Forty-two cases with two deaths make my mortality in vaginal hysterectomy 4.76 per cent., a little lower than the average in ovariectomy.

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—In the *Centralblatt für Gynäkologie*, 1893, Sanger reports a case of triple ectopic pregnancy in which a twin pregnancy was found in the wall of the uterus, while a third ovum was discovered in a blood clot at the fimbriated extremity of the right tube. A careful examination of the case showed the condition to be an intramural twin pregnancy at the point of entrance of the right tube into the uterus, while at the abdominal end of the same tube there was a third ovum, the whole being an example of unilateral ectopic triple gestation.

## REMOVAL OF THE ENTIRE UTERUS TOGETHER WITH THE APPENDAGES, FOR UTERINE FIBROIDS.

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BY

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pital ; and to the Hahnemann Hospital, New York.

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SINCE sending the title of this paper to our chairman, I have been able to clinically verify the entire practicability of an operation that I have advocated for several years, namely: when we remove the ovaries and tubes for diseases of which they alone are the seat, we not only can, but should remove the uterus also. With your permission, therefore, I will include the above proposition in this discussion, reserving it, however, for the close of this paper.

With a better understanding of the principles of operative surgery, and the perfecting of surgical technique, many operations are justifiable and possible that formerly would not have borne the test that should be applied to all scientific procedures. Thus it has come to pass that abdominal surgery occupies its present proud position, for as a rule knowledge must precede practice, and while surgeons for many years prior to the work of our countryman, Ephraim McDowell, believed that abdominal tumors should be removed by operation, it has only been by the elimination of sources of failure, the removal of erroneous conservatism, and the perfection of methods that we are able to show such great results in this branch of our art.

Especially does what I have said apply to the treatment of uterine tumors. Ovariectomy was recognized as a legitimate operation long before hysterectomy was placed in the same position, and even now in some quarters, among those

who advocate electrolysis, the advances of this branch of abdominal surgery are steadily resisted. But we cannot discard well-founded theory, or refuse facts gained from clinical experience.

There is nothing in the operation of abdominal hysterectomy *per se* that should give the high mortality that we have heretofore been obliged to record. With improved technique, hysterectomy for uterine fibroids should not give a higher mortality than ovariectomy. The length of incision necessary to remove a large tumor has long ceased to be regarded as influencing one way or the other, and the manipulation of the abdominal organs need be little more than in ovariectomy. Of course there is more manipulation than in a plain going ovariectomy, but not more than in cases in which there are adhesions to break up and tie. I think, therefore, we are justified in concluding that the former mortality of abdominal hysterectomy is in a large measure due to the method of operating, to an erroneous conception of pelvic physiology, and to false conservatism.

What, for example, when applied to any other department of surgery, can be less in accord with modern surgery, than to leave in position a part already diseased, or, judging from its previous history, one that will very probably become diseased? Or what is less in accord with all antiseptics has taught us, than deliberately to invite suppuration and sloughing of tissue, as in the extra-abdominal treatment of the uterine pedicle? Why, it may with reason be asked, should we leave the appendages or any part of the uterus when the major part of the latter organ is taken away? We have long since given up the clamp in ovariectomy, why should we continue its use in hysterectomy, and why should we leave any pedicles to clamp? It is a cardinal principle of all operative surgery, that the risk incurred is in proportion to the tissue constricted, and that the ideal method of controlling hemorrhage is by ligating the artery only; in proportion as we apply the

general principles of surgery to abdominal work, and do not make it in any sense an exception, I believe we will make it a success. The abdomen is not different from other parts, save that it contains organs essential to life, and is practically a closed cavity ; and if we work here as elsewhere, carefully, expeditiously, with cleanliness, removing all diseased tissue, tying all arteries, and providing means for escape of injurious fluids, laparotomies should be attended with no more danger than any other major surgical operations.

But it is unnecessary to dwell on the advantages to be derived from leaving no pedicles in abdominal hysterectomy ; they are apparent and need not be defended. The question is, How can this be accomplished with a minimum risk? From the cases that I have had during the last winter, eight in number, in which I have removed the entire appendages for uterine fibroids, I am led to believe that this operation is less dangerous than under the old method of clamping a uterine pedicle. It is certainly more difficult, but this should not weigh against the advantages gained. All of the eight cases have recovered promptly, with but little suffering, and with really no constitutional disturbance. Indeed, the usual symptoms of change of life so frequently observed after double oöphorectomy have not been well marked. With increased facility there has been a corresponding decrease of shock attending the operation, the last operation having been completed in thirty minutes. This patient walked from her bed to her chair on the eighteenth day, and returned to her home in four weeks.

My method of operating is simple and capable of great rapidity, a matter of importance to the patient, when consistent with safety. After opening the abdomen, and I make the incision large enough to allow free manipulation, I raise the tumor by screwing into it by broad flanged cork-screw. With curved needles which I have had made for the

purpose, I ligate first the left ovarian artery as near its origin as possible. I then tear or cut the broad ligament down to the vaginal vault. This brings the uterine artery into the field of operating, which is tied in the same manner as the ovarian artery. The right side is then treated in a similar manner. The bladder is next separated from the anterior uterine surface, and then the rectum from the posterior surface. It will be found that the tumor, uterus, and appendages can be lifted out of the pelvis. But four ligatures remain as the result of the operation, and after placing a drainage tube in the vagina the abdominal wound is closed.

Now upon drainage I lay great stress, and consider that upon its accomplishment depends much of the success of the operation. For in the first place, it is an indication of what is going on in the abdominal cavity, and in the second place, it acts as a safety valve for congestion of the peritoneum. But I have found considerable difficulty in maintaining vaginal drainage, for while this is the mechanical drain of the abdominal cavity, it is a fact that the vagina tends to close more rapidly than is consistent with perfect and continued drainage. Moreover, the pelvic organs seem to fall upon the drainage tube, and close its mouth.

I have tried various methods: the Latin-cross drainage tube, the glass drainage tube, and iodoform gauze; not one of these has in my hands so far furnished the ideal vaginal drainage. If any preference is given, I think it is in favor of a curved glass tube, or a tampon of iodoform gauze. Either one of these keeps the vagina open, the latter specially, while the rubber tube closes, and the discharge takes place outside of it.

I have come to look upon a free discharge during the first twenty-four hours as rather favorable than otherwise. Not of blood, for this should practically cease in six or eight hours, but of a bloody serum, for this indicates that the peritoneum is functionally active, and therefore

that the pelvic circulation is not in any way interfered with.

The time for removing drainage depends upon several conditions. A feeling of local uneasiness or pain in the rectum, or an absence of discharge, will point to its removal, for when these conditions exist, the tube has fulfilled its office, or is not doing its work well; in either case drainage should be discontinued or re-adjusted.

In some cases, when the tumor is very large and grows low down in the pelvis, it may be necessary to apply the temporary clamp before tying the uterine arteries. This happened in two of my cases, but I think it must be exceptional, for after liberating the upper border of the broad ligament the principal obstacle to raising the uterus is removed.

There is sometimes rather troublesome bleeding from the posterior vaginal opening, though why, I cannot say, for all circulation is cut off from the azygous artery after tying the uterine arteries, of which it is a branch. Possibly there is some anomaly of the circulation. It therefore would probably be good practice always to sew the serous and mucous surfaces together with fine catgut before closing the abdominal wound.

I am of course aware that only very imperfect deductions can be drawn from eight cases, but in reviewing these they compare so favorably with those operated on by the extra-abdominal pedicle method, both as to mortality and convalescence, that I am forced to the belief that the principle is a true one, whatever may be the changes and future improvements in the technique of operating. As an effect, against the great suffering and prolonged convalescence attendant upon the suppurating pedicle and consequent dangers of septic infection of the older methods—and of all these I regard the elastic ligature and pins the most pernicious—we have the minimum degree of suffering: I have never been obliged to give morphine after this operation,

a convalescence that is not prolonged over more than three weeks, no suppurating pedicle, and no danger of septic infection. I do not regard this operation as so severe as the older one, nor should it be as long, for usually much time is consumed in making and securing the pedicle. From all aspects therefore, theoretic, scientific, and practical, I think we must look upon the removal of the entire uterus together with the appendages for uterine myoma as an operation in advance of the older one of leaving a part of the uterus to form an extra-abdominal pedicle.

Let me add a few words concerning the removal of the uterus when the operation is undertaken for diseased appendages. For several years I have considered this an operation that we must resort to if we would give our patients the chances of recovery that they have reason to expect from the scientific attainments of the day. The technical difficulties in the way of its accomplishment have, however, until recently deterred me from carrying it into practice; but with a growing disregard of a long abdominal incision, with the advantages conferred by the Trendelenburg position, and with a confidence acquired from my success in total extirpation of the uterus for fibroids, I do not now hesitate to remove the uterus together with the appendages when the latter alone are diseased. The five cases in which I have performed this operation have been perfectly satisfactory. But one died, and that death was not the result of the operation, but was due to the excessive restlessness of the patient, and her unruly disposition. These together brought on fatal secondary hemorrhage.

The advantage of this operation over the certainly less severe one of double oöphorectomy is that the cure is a radical one. I think any laparotomist of experience will agree with me that cases of the removal of the appendages are not always followed by the expected brilliant results. Pain continues, frequently more severe than before the operation. The uterus remains sensitive, generally becomes

displaced, either backward or downward; in other words, becomes after the removal of the ovaries and tubes a foreign body, and as such is subject to the laws that govern such bodies. Again I repeat, that with improved technique, and with a better understanding of reproductive physiology, to cure our patients, when it becomes necessary to remove the appendages, we must also remove the uterus if we would give them all that they have reason to expect at our hands.

My method of operating is very similar to that of removing the uterus and appendages for uterine tumors. The manipulation, however, is more difficult, for the reason that no large foreign body has existed to push or to displace the pelvic viscera upward; but with a large incision, and with the intestines held out of the way, the operation is rendered comparatively easy.

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### CONDUCT OF OBSTETRIC CASES.

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BY

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IN olden times, ergot, by its incautious use, was a fearful implement of destruction in the hands of practitioners of midwifery. It was especially the "help at hand" for the midwife. Its power for evil to both mother and child is so great that medical men of the best repute have practically abandoned it altogether as a *parturient*. The following aphorism from Professor Pajot we fully indorse: "As long as the uterus contains anything, be it child, placenta, membrane, or clots, never administer ergot." We are aware that not a few practitioners will give ergot for inertia uteri after delivery, but we insist that it should not be given unless the placenta is passed, and the uterus free of clots. Then its opportunity for legitimate use is as



a hemostatic, in the prevention and cure of *post-partum* hemorrhage. Ergot was once designated as *pulvis ad mortem*. Formerly, we had no little trouble in the use of ergot for the want of a permanent and reliable preparation. Several preparations of the fluid extract are now obtainable which are excellent, but the preparation coming to us and called ergotole, from Sharp & Dohme of Baltimore, is the best, and will be found more efficient than any other. In this connection, it may be well to mention hot water irrigations, as one of the best hemostatics in not only midwifery practice, but also in surgical practice. In cases of *post-partum* flooding, should hot water not suffice, its alternate use with ice-water injections may be serviceable as a means of startling the patulous sinuses into healthy contractions.

We have recently arrived at a much safer and better understanding as to the indications and contra-indications justifying and requiring the use of forceps. Many a woman and child have been lost for the want of prompt and timely use of this valuable instrument; while others have been sacrificed by its incautious and premature application.

When the labor is protracted, and either mother or child is in any danger from the delay, and the danger will cease with rapid delivery—if the circumstances are such that the forceps may be used—they are always indicated.

As a substitute for the Cæsarean section, much interest just now is being exercised in behalf of symphysiotomy, or synchondrotomy. Of course this operative mode is not a novelty. It was proposed and practiced a very long while ago. First by De la Corrué in 1634, then by Sigault in 1768, and by Stolz modified into a pubeotomy. Winckel of Munich says of the operation:

“It has not fulfilled what was promised of it, but has produced, in many instances, what was not expected—injuries of the bladder, stretching of the sacro-iliac articulations, and caries of the anterior wall of the pelvis. May

this be forever entombed!" Notwithstanding the above, from so conservative and experienced a man as Winckel, we are obliged to keep up with the changes and experiences of this present age.

Recently, under the advantages of superior surgical skill, combined with our practical experience of aseptic procedures, some encouraging results are said to have been attained from this operation. Obviously, the advantage to be gained is in saving the integrity of the peritoneum and the uterine wall. We therefore hope for this operation a creditable success in the near future. The drawback in the operation would seem to consist in tardy re-articulation of the divided symphysis. With suitable surgical pelvic constraint, and requisite avoidance of locomotion, this difficulty may possibly be reduced to the minimum.

The operation known as episiotomy, while not a novelty or anything new, has recently been brought into more pronounced notice as a means of relief to prevent laceration of the perineum. The operation is very simple, consisting in making lateral incisions into the labia. It has been called, "the young practitioner's operation." This is an unjust fling against it. It is an operation practiced in the best lying-in institutions in Germany. We first learned it when a pupil of Professor Braun in Vienna, and have had occasion to practice it occasionally for the past thirty years. Any mode of management which so safely and simply prevents the dire disaster of perineal rupture ought not to be lightly esteemed. These lateral incisions repair soon with or without trifling surgical assistance. It may be advisable in some cases to apply catgut sutures. In this place, we have a word to say as to the *time* for surgical repair of a lacerated perineum. In olden time repair was postponed almost indefinitely and attempted in very bad cases.

A great deal of the work the gynecologist has to do is caused by the injuries that happen during parturition. To

protect the perineum during the passage of the child's head and shoulders is the duty of the skilled accoucheur. Lacerations of the perineum, unrepaired, cause untold miseries to women, and render their lives wretched. They are liable to occur in labors where instruments are not employed, or they may result from their unskillful use. But such accidents often happen to the most experienced and skillful obstetrists, and the circumstances of the case may be such that they cannot be avoided. After every labor the accoucheur should (before leaving the lying-in room) carefully examine the vulva by an ocular inspection to assure himself of its exact condition. If rupture of the perineum has occurred, it is his duty to repair it at once.

This should be done as soon after the delivery as may be practicable—within the first six hours if possible; it is unsafe to wait longer than sixteen hours. However, in two cases in my own experience, the operation proved a success when made twenty-four hours after the delivery. The consensus of opinion of the authorities in midwifery the world over, now insists upon the *immediate* repair of a perineum ruptured during labor. In giving this opinion so positively, it may be supplemented by the statement that there are exceptions to this rule—the circumstances of the case may be such that the primary operation will be contra-indicated.

An operation for laceration of the cervix during labor may with entire propriety be deferred beyond the puerperal state, and yet its immediate repair is already advised by some experienced obstetricists.

Saturating the vulva with hot oil, to be kept hot by frequent applications of compresses out of hot water, has recently come into such use and favorable notice as a simple and practicable means of relaxing the unyielding parts threatened with lacerations. This is practiced just when the head is ready to pass through the outlet.

To Dr. Thomas of New York belongs the credit of

having recently introduced and practiced a modification of the Cæsarian section as a substitute for craniotomy. It is known as laparo-elytrotomy. Its object is to effect delivery in pelvis deformities without craniotomy, and at the same time save the integrity of the peritoneum and the uterine wall, an object and result most devoutly to be wished for by every cautious and conscientious practitioner. No prudent surgeon ever passes his knife through these parts without a painful misgiving, with all the precautions against sepsis. The initial incision in this operation is made an inch above Poupart's ligament. Then by a cautious dissection and separation of the peritoneum from its sub-cellular connections, it is pushed up so as to enable the surgeon to dissect down to the cervical end of the vagina, which is freely cut laterally (across) so as to reach the fetal head through the os and deliver above the symphysis pubis. Anatomical familiarity with the parts, a steady hand, and a bright eye render the operation by no means difficult; and while statistics are by no means all that might be desired in the way of favorable results, yet the operation promises well as a *dernier ressort*. In extenuation of any unfavorable result in this and kindred cases, it should be borne in mind that surgical interference is usually deferred until the bodily vitality of the mother is so low that the simplest surgical operations are liable to terminate disastrously.

Occipito-posterior position of the fetal head in labor has of course been liable to occur at any time since labor and child-bearing came to be a fact. Yet it does not seem to have received careful recognition and systematic attention until recently. According to Dr. Uvedale West, who studied the subject very carefully, it seems to have occurred 79 times in 2585 labors; all of the labors being exceptionally difficult. The failure of recognition seems to grow out of a seeming obscurity of the parts in the matter of examination. I remember at a medical society one

evening, the manikin with the fetal head in this position under cover was presented for opinion from several men of ability and experience. Not one of them recognized or diagnosed the position correctly. Practically, the state of the case consists in the failure of the occiput to rotate anteriorly toward the symphysis; so that the occiput is situated posteriorly at the promontory, while the forehead and face is at or under the symphysis, presenting the very longest diameter that can be made of the face and cranium, to one of a shorter pelvic diameter. A marked peculiarity of such cases is, that the chin instead of being pressed down upon the sternum is drawn as far away as possible; this fact serving as an important element in the matter of diagnosis.

Three modes of management have been suggested: The first is to leave the case to the efforts of nature, under the hope that a spontaneous rotation of the occiput may bring it under the symphysis and so terminate the labor as one of the normal varieties. And, what is remarkable, not a few of such cases thus terminate favorably by the unaided powers of nature. The second is to make a pressure upon the frontal bone so as to bring the chin to its normal position on the sternum, while making oblique lateral pressure on the head under the symphysis, with a view of inducing rotation of the occiput toward the symphysis. In fine the manipulation of the accoucheur should be such as to constantly favor *flexion* of the head, which will facilitate the descent of the occiput, and resist the descent of the forehead, by pushing it toward the sternum, keeping it in a constant state of flexion.

The third method is to deliver with the forceps with the occiput posteriorly. In the main, experience will show from the results of any or all three modes: that it were much more lucky to have escaped the case altogether, than to be responsible for its management.

The question whether it is ever a legitimate operation to

destroy the child's life to save the mother, is one that must be answered. We will not discuss it *in extenso*, for we could easily write many pages upon it. To sum up: Cases may occur where the labor has been greatly prolonged, where the mother's pulse is very rapid and weak, and the temperature so high as to indicate danger from complete exhaustion, that may terminate suddenly with death, unless she is relieved by immediate and rapid delivery. Added to this, the pulsations of the fetal heart are very faint—indeed, almost inaudible—and consequently the absolute indications for the Cæsarean section are absent. In such a dilemma, when the mother cannot last much longer, if the obstetricist (who we will suppose is an expert as a surgeon) elects to make a rapid Cæsarean section—either by the Porro or Sanger method—in all probability the result will be fatal to both mother and child. Either craniotomy or embryotomy must be a last resort. So many objections are made to this serious operation, that the practitioner must be certain that there is *nothing left but a resort to it*. A short time since, we were in consultation with a celebrated practitioner (an ex-professor) in a case of lingering labor, with occipito-posterior position, where the head was impacted and rotation could not be made. The forceps were tried, but it was impossible to effect the delivery. The ex-professor proposed the Cæsarean section, but the family dissented in the most positive terms. The doctor insisted that he would withdraw from the case if the operation was refused. The impaction was so firm, the mother's condition so low, and the child's vitality in such doubt, that craniotomy was the only resort.

In the matter of therapeutics peculiar to utero gestation and the puerperal state, there is such a growing tendency to consider these states physiological and normal as to discourage the practice of drug administration almost altogether. In obstetrical therapeutics we have recently made more ad-

vance in the uses of electricity than in any other direction. This agent has come to the front recently after such fashion in commerce, science, art, propulsion, and heat as to make one's head almost giddy when he stops to think of present realities and immediate future promise. To the obstetricist it possesses peculiar interest in the management of uterine inertia and spastic irregular uterine action.

In the severe lumbar pains of the first stage it serves a valuable purpose ; also for cramps of the lower extremities in the second stage. For such purposes, both the galvanic and faradic currents will be found useful, in accordance with the special symptoms. The destruction of the fetus in extra-uterine pregnancy by the faradic current has been recently proposed and received practical attention. If the dead fetus becomes encysted so as to convert it into a benign tumor, we may have relatively a happy solution or conclusion of a grave difficulty. Should signs of decay and disintegration take place after the faradic application, we should promptly resort to laparotomy, to save the patient from the horrors and complication of a widespread septicæmia. We should say of such cases as we did of occipito-posterior position ; it is much better to escape them altogether than to be responsible for management and result.

The puerperal state is subject to various febrile disorders : some transient ; some more permanent. We think the peritoneal form usually known as *puerperal* fever is less frequent than formerly, and even now not so frequent as may be supposed. We believe there is a puerperal fever which is a *zymotic* affection or an essential disease, and other forms that are septicæmia. No doubt the majority of puerperal fevers originate from heterogenetic causes ; and may be regarded as puerperal septicæmia *de facto*, as a septic process, and closely allied to surgical fever.

No doubt cases of puerperal fever may occur from auto-infection, as well as hetero-infection. When the results of traumatism are considered it would seem in certain cases to

be independent of either. The practical thought to be kept in mind is that woman in the puerperal state is much predisposed to the adverse influence of any toxic agent that may happen to be near her. Precisely the reverse is true during utero-gestation. But in the puerperal state, neighborhood of cases of any malignant or contagious form of disease always renders puerperal fever probable. Physicians in attendance upon diphtheria, scarlet fever, or malignant typhus should decline all obstetrical calls or engagements. Physicians afflicted with obstinate chronic ulcerations and discharges, *e. g.*, ozæna, should never trust themselves in the lying-in chamber. It does not seem probable—only exceptionally—that this fever is propagated by any specific contagion, as we find in the causation of smallpox, scarlet fever, measles, and whooping cough. Yet if of two women in the same ward or room, both in the puerperal state, one should chance to get puerperal fever, she will very likely communicate it to the other.

As perfect asepsis in labor is the first care of the obstetricist, antiseptic agents should be always within reach. There is quite a list of them that possess distinct virtues.

Hot sterilized water, boric acid, calendula, listerine, corrosive sublimate, creolin, and lysol all have their especial uses as antiseptic agents; but after sterilized water, *lysol* is the most reliable. It is one of the most powerful germicides that we possess, and in gynecological and obstetrical practice is perfectly innocuous. It is not costly, being derived from tar oils by boiling with alkaloids and fats. It is employed in solutions of from one-half to three per cent. Sublimate, which is a powerful germicide, is dangerous to some patients. Drs. Welch and Vance think that it has already done more harm than good. We are not quite ready to banish it from the accoucheur's armamentarium, but it must be used with great caution. In a solution of 1-10,000, in our own experience it is absolutely safe. In organic kidney affections it is contra-indicated. The



trouble with it would seem to be that it is an agent so powerful that we are all the while in danger of getting more than we bargained for. The puerperal woman would seem to be especially susceptible to its toxic action, as deaths have been reported from its use, when used in a solution of 1-1500, and possibly in solutions still weaker.

The obstetricist will by no means seem to have discharged his whole duty without suitable attention to the little stranger. Formerly, if the said stranger indulged anticipations as to the immediate future after his arrival, he expected a hearty scrubbing in hot soap suds as a means of bodily renovation, at the expense of damage to both skin and eyes. Now we treat him to frictions in warm oil, followed by a warm bath without soap, and drying frictions with warm soft cloth, all accomplished so dexterously and quickly as to save exhaustion and bodily depression. If he arrive in anything like a feeble or bad condition he gets the warm oil frictions only, and is at once enveloped in a soft warm blanket.

The former elaboration of finery in dress for the young child should in all cases give place simply to a cotton flannel gown, a buttock napkin, and the "belly band."

The eyes and mouth should be carefully washed with a *new* sponge and warm water. Should there be a reason to suspect any specific or unclean condition of the mother's genitals, the eyes should be treated to a drop of corrosive sublimate, 1-4000; or a drop of nitrate silver solution one per cent. strength; to be followed by a ten per cent. solution of boric acid three times a day as a lotion, for one week. This precaution may save the practitioner, as well as the child, from the horrors and consequences of *ophthalmia neonatorum*.

If the child be a male, carefully examine the aperture of the foreskin, and if very narrow, dilate at once, and completely expose the *glans*, in order that it may be kept clean, and that there shall be no phimosis.

## THE HABITUAL DEATH OF THE FETUS IN UTERO.

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BY

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MRS. —, age twenty-eight years, American, large and strong, came to my clinic February, 1893, and asked this question: "Why is it that I cannot give birth to a living child?" The history she gave was as follows: She had been married eight years, had always had perfect health, never having employed a physician except as accoucheur, never had taken any medicine, and says that she is in perfect health now. Except at confinements she has never been ill and had recovered promptly and perfectly from four labors. She looked the picture of health, but her misfortune had caused a deep melancholy. She returned three times, and with all the quizzing I could give or examinations I could make, I could not find any cause for her unnatural labors.

Turning my attention to the possibility of the husband's health as a factor in the child's death, I could not discover that he had ever had any disease that could have accounted for parental influence causing immature children. In detail let me say that the mother had conceived and carried without inconvenience, up to the time of the fetal death, in a perfectly natural manner; she never had shown a sign of (1) syphilis; or (2) anæmia; (3) uterine disease or any its appendages; (4) uterine displacement; (5) cellulitis or peritonitis; (6) laceration of the cervix; (7) fevers; (8) chorea; (9) Bright's disease; (10) tumors; (11) poisoning from lead, arsenic, etc.; (12) metritis or liver diseases; (13) traumatisms; (14) intemperance; (15) narcotics or opiates; (16) heredity did not influence her

case, as all of her sisters are mothers; (17) abortions; (18) kidney lesions.

On the husband's side: he had never suspected that he had in any way had (1) syphilis; (2) nephritis; (3) diabetes; (4) phthisis; (5) cancer; (6) he was in the prime of life, never had been intemperate; (7) no eruptive diseases; (8) brothers were fathers; (9) no malaria; (10) no tobacco or lead poisoning; in fact it was difficult to obtain a single clew to any physical defect through indiscretions or disease.

We next turned attention to the cause of death of fetus, as each miscarriage was due to the presence of a dead fetus *in utero*. The first child she carried during eight months of gestation; when born, it had been dead several days. The second child was born at the fifth month. The third at the seventh month, and the fourth at the eighth month. All the children seemed perfectly formed, were not macerated, and so far as the patient could tell, there were never any marks of syphilis. Once the attending physician said that there was something the matter with the cord, but she never had any explanation given her, and renewed the question fervently, "Why can I not have a living child?"

These cases, so far as the aggregation is concerned, are not especially rare, but they do not occur frequently in individual practice. Each practitioner could probably narrate one or more cases, but taken as a class of cases they are rare. Two pertinent questions arise here: "What are the causes?" "What can be done?"

The answer to the first question, as found in the recent literature, is very briefly condensed in the following list of causes of death of the fetus. (a) *The premature detachment of the placenta*: (1) nephritis; (b) *Diseases of the placenta*: (1) syphilitic, (2) infective fevers, (3) tuberculosis, (4) apoplexy, (5) infarct, (6) torsions, (7) inflammatory changes, (8) fibrous bands. (c) *Diseases of the fetus*: (1) torsion of the

cord, (2) partial or incomplete development of the cord, (3) thrombosis, (4) mummified fibrous cords, (5) fatty degeneration of the cotyledons.

What can be done? The answer is plain. The majority of these cases will trace out to be either syphilitic or else to be accounted for by the velamentous insertion of the cord. The former is recognized best by microscopical examination. This examination should be made immediately after the expulsion of the placenta. The presence of gumma or syphilitic nodules is the true test. Fraenkle has never been able to demonstrate syphilis of the placenta earlier than the sixth month.

The marginal attachment of the cord and the white infarct of the placenta or the various torsions are beyond the power of the diagnostician or of any form of medical interference. In the cases where the lesion exists, as in the nerve centers or circulatory system, hygienic conditions and constitutional treatment is the only form of treatment that promises any measure of success. In the cases similar to the one I refer to, there being no lesions, I would try the treatment usually known as the anti-syphilitic, using mer. cor. 6x trit. once daily for some months. In case the lesion is syphilitic, repeated pregnancies have been known to have the effect of elimination, and the mother may finally give birth to the child, viable and full of promise.

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## THE RATIONAL TREATMENT OF CERTAIN PUERPERAL DISORDERS.

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BY

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IT is related of an ambitious but pretentious lawyer, that during his first argument before the Supreme Bench of the United States it became necessary for the Chief Jus-

tice to interrupt him with the suggestion that "This court may be presumed to know *something* about law!" The admonition of the eminent jurist is not unheeded. I assume that he who takes the time and the trouble to read or to listen to these words is tolerably familiar with the present teachings of the science of bacteriology, and the present state of development of the germ theory.

Bacilli have been devoted attendants upon the human race, lo, these unnumbered ages. We made their acquaintance but yesterday. Not too late, however, for they will continue to abide with us a few centuries longer. It is for us simply to determine upon a proper style of deportment toward our newly discovered companions.

The practical relations of human beings to such tiny yet murderous associates are susceptible of a threefold division, natural at once and logical. The underlying conditions are, *first*, the obnoxious microbes outside the unbroken covering, cuticular or mucous, of a vigorous healthy body; *second*, their actual storming of more or less accessible breaches in the vital armor, occasioned by violence or by physiological processes; *third*, their establishment of camps within the human frame. Evidently the functions of a physician toward these conditions are as diverse as the situations indicated, although in any given instance he may be compelled to discharge them all. Concerning the bearing of a surgeon toward disease germs I will not presume to speak, although elsewhere I have intimated, by reference to unimpeachable authority, his subjection to the same principles which shall govern his brother.

If a physician is consulted concerning pertinent matters, when thoroughly satisfied none of these little creatures have discovered an entrance to his patron's body he must act simply as a hygeist. To the performance of that duty, however, he should bring all attainable knowledge of the resources of sanitary science. This service has singularly

enough been dubbed by some preventive medicine, an incongruous and absurd appellation!

Should a doctor succeed in catching any of the well nigh omnipresent wanderers in an attempt to scale any breach opening to the citadel of life, he would at once thoroughly though *gently* sweep thence the invading hosts, for as was shown in detail one year ago, experience and bacteriology alike forbid the application of corrosive or irritating substances to raw surfaces.

If aid has not been summoned until invasion has been measurably accomplished the attendant's duty is still unmistakable. Since the chief physiological disturbances and anatomical changes (pathological conditions) subsequent to the lodgment of these impalpable foes within the human frame are the direct result, not of themselves nor yet of their work, but of the efforts of the organism to free itself from their presence, it follows as naturally and as inevitably as does the day and night that the *proper* course of action is the administration of medicaments which shall intensify and sustain (reinforce) the exertions of the affected organism in its endeavors to expel the intruders, in other words, the dispensation of remedies capable of producing corresponding phenomena when given to the healthy and sound. The possession of such property by any substances can be definitely known of course only through antecedent experiment.

Parenthetically it may be remarked (*a*) that it is perfectly proper to speak of a person's being threatened with any one of many of the so-called diseases. Should an invading host be routed before it had deployed its columns, before it had clearly manifested its character, any assumption consistent with the apparent phenomena would be legitimate. (*b*) The inherent possibility of overwhelming the enemy at any time is also evident, although the synchronous destruction of his works is neither claimed nor expected. A reported cure at any stage of any case of an infectious dis-

ease requires therefore no stronger proof than other commonplace statements of alleged facts.

To resume: since the laws of nature are general, not to say universal, originating not in human formulation but in the established constitution of things, and since the known field of infectious diseases is broadening with marvelous rapidity while extreme uncertainty attends the limitation of its boundaries, it is clear that with him lies the burden of proof who dares affirm that the administration to the sick of remedies capable of producing corresponding phenomena when given to the healthy is not the proper course of action in all curable cases.

Finally since the character of the work of many microbes varies with the age, sex, and condition of their victim, and since autopsies frequently reveal their unsuspected presence at important points, there is no reason to expect a parasitic pathology will prove a more reliable guide in the healing art than have been the humoral, the methodic, and the pneumatic. Hence naught remains for the true physician but to exemplify the singularly significant motto of this World's Congress, and day by day to treat "*Not Things but Men.*"

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## THE YEAR'S PROGRESS IN OBSTETRICS.

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BY

PROFESSOR SHELDON LEAVITT, M. D.,

CHICAGO, ILL.

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FOR several years progress in the art of obstetrics has been mainly along surgical lines, until so much operative work now pertains to the complete practice of this branch, that he who expects to rely upon himself in the hour of emergency must possess surgical skill. Moreover, require-

ments for the successful practice of obstetrics are daily becoming more exacting. Midwives and incompetents will ultimately be driven out of the field by the lash of public sentiment.

*Symphysiotomy.*—The old operation of Sigault, known as symphysiotomy, which had quite a run in the latter part of the last century, has been revived in this our day by the Obstetric School of Naples, and thus far has had a good record. In this country it has been employed but few times, but the sentiment of accoucheurs appears to be friendly toward it.

It is only occasionally appropriate, and probably far less frequently in this country, and especially in the West, than in the more densely settled countries of Europe, where pauperism is more prevalent and the people are harder worked and more poorly fed.

Ever since the original operation of Sigault fell into desuetude, obstetricians have busied themselves in efforts to devise methods for reducing the size of the fetal head to correspond to pelvic dimensions, and, as a result, thousands of fetal lives have been sacrificed for want of the very expedient which had been cast aside.

It is unnecessary for me to say that the secret of our success with Sigault's operation to-day is found in cleaner methods and finer technique.

For some years Cæsarean section has been the standard operation for cases in which the antero-posterior diameter of the brim was reduced as low as  $2\frac{3}{4}$  inches; but recently a living child has been delivered by means of symphysiotomy when the diameter was only  $2\frac{1}{2}$  inches. The wonderful improvement in obstetrical results which this affords is at once apparent when we consider the vast difference in point of mortality between the two operations, Cæsarean section and symphysiotomy. Nor is maternal life preserved at the expense of subsequent misery, for according to the reports thus far made, there are no disabling effects



produced in the woman as the result of temporary disarticulation of the pubic bones.

Still we are to recollect that the operation is yet on trial, and should lay corresponding restraint on our enthusiasm. The true value of it can better be told in a twelvemonth.

After the os uteri has been fully dilated, and futile attempts have been made to deliver with the forceps, or as soon as we find that the fetal head is unquestionably so decidedly out of proportion to the size of the pelvis that delivery of a living child cannot be effected, the time has arrived for the performance of symphysiotomy.

The field of the operation is prepared in the usual manner (which preparation should include shaving the mons veneris and vulva), and an incision is made about two inches long in the median line, the lower limit of it being a point just above the clitoris. A few fibers of the rectus muscle are separated from the pubes on either side of the median line, and the finger is passed down along the posterior surface of the symphysis. Using the finger as both director and protector, a curved probe-pointed bistoury is then made to sever the articular soft structures, including the subpubic ligament, great care being exercised to avoid wounding the other structures. The articular surfaces are gently separated a few lines, the wound is examined for bleeding points, these being secured with fine catgut, temporary gauze packing is used and the forceps are applied. Delivery should be practiced with great care, and during traction effort the trochanters should be supported by the hands of the assistant. After delivery of the placenta the gauze is removed, the control of all bleeding assured, the articular surfaces are brought together and held by silk-worm-gut sutures through the fibrous structures along the face of the bones, which fall within easy reach, and then the external wound is closed. In exceptional cases it may be wise to practice drainage for twenty-four hours. A tight bandage should be applied to the hips and firmly

secured. The recumbent posture should be enforced for about four weeks.

*The Cæsarean Operation.*—I am not aware that there has been any improvement worthy of mention in the technique of the Cæsarean operation or its modification during the past year, but the sentiment is becoming nearly universal that the operation should be regarded as elective in the matter of time. Formerly the custom was to resort to surgical interference only after labor had been well established, and that, too, even in cases wherein delivery *per vias naturales* had been recognized as impossible.

Without pausing here to note the objections which have been made to early interposition, I may be allowed to emphasize the advantages arising from *ante-partum*, viz.:

1. A better opportunity for deliberate and painstaking preparation on the part of the operator is afforded.
2. Daylight can be assured.
3. The patient can be more thoroughly prepared.
4. The vital powers of the woman have not become seriously impaired.

In view of the bearing of the exact pelvic and cranial measurements on the selection of the most suitable operation for an individual case, I should not omit to direct your attention to the demand for more frequent use of the pelvimeter, and a careful estimate of cranial dimensions which the introduction of symphysiotomy has established.

*Sänger vs. Porro.*—Cæsarean section, pure and simple, as practiced by Sänger, and Cæsarean section as modified by Porro, are still rivals for surgical favor. In Italy, where it originated, the Porro operation is by far the most popular, while in Germany Sänger's operation is in greater favor. The surgeons of this country have exhibited a preference for the latter method, though some of the best operators are outspoken in their preference for the former. Dr. Robert P. Harris, whose statistics are most elaborate and reliable, believes that Americans have good reasons for pre-

ferring the improved Cæsarean operation, inasmuch as twelve out of twenty-eight Porro subjects up to the present time have died, against five out of the last twenty-eight delivered under the other method. On the other hand, "Our success," says Dr. Joseph Price, who has thus far produced the best statistics of personal abdominal work which the world affords, "in supra-vaginal extra-peritoneal hysterectomy for fibroids, and the low mortality accompanying the operation, has assured our faith in the Porro operation. Hysterectomy should be performed," he continues, "wherever the Cæsarean section is necessary." Thus the controversy goes on, but out of the din and smoke of the tumult we gather indications of the advantage of the Porro over the Säger operation for the use of the average surgeon and gynecologist outside of hospital walls.

It is more easily and expeditiously performed, and, what to my mind commends it still more, the possibility of future impregnation is prevented. The sentimentality in which some indulge, and the amiability which would encourage reproduction by such women of weak, deformed, and usually dependent children, should be discountenanced. The record which Rosenberg found of thirty-six cases wherein Cæsarean section had been performed from two to five times on the same woman is to my mind deeply revolting.

As in the case of supra-vaginal hysterectomy under other circumstances, some late operators have treated the stump according to various intra-abdominal or intra-pelvic, if not strictly intra-peritoneal methods; but the ordinary operator will still prefer to fasten the stump at the abdominal opening.

*Cæsarean Operations vs. Craniotomy.*—The accoucheur who possesses surgical skill will hereafter reserve his craniotomy forceps and his cephalotribe for use only upon the dead fetus, for, with the child living, abdominal section and symphysiotomy are the operations to be considered.

Upon a dead fetus, in a pelvis measuring in excess of three, or at the least two and a half inches, such instruments will afford occasional aid, but not elsewhere. This is the dictum of late obstetric authorities, and yet I can conceive of an occasional case in the experience of those who have no surgical skill themselves, and cannot readily summon those who do possess it, wherein an exception to this rule may properly lie. The practitioner who is inexperienced in surgery of the abdomen, but who is accustomed to obstetrical manipulation, will be less likely to do serious harm with the perforator and allied instruments than with the knife; and to such cases, with an environment decidedly unfavorable so far as concerns consultative facilities, rigid rules cannot be applied.

*Ischio-Pubiotomy.*—I should not fail to refer to a congener of symphysiotomy known as Farabeuf's operation, which consists of section of the pelvis at a point about two inches to the right or left of the symphysis pubis, according to the direction of the pelvic contraction. It is intended for cases of obliquely contracted pelves, wherein symphysiotomy would be comparatively ineffectual. The most recent example of this operation of which I have seen a report is from the clinic of Professor Pinard of Paris.

In order to make the result of this operation satisfactory, as it appears to me, the greatest care will be requisite, owing to the presence, at the site of section as designated, of the obturator nerve which supplies adductor muscles of the thigh. In measurements recently made on the cadaver, I find that the point of exit of this nerve, at the upper and inner margin of the obturator foramen, is just two inches from the symphysis. The obturator vessels are also found at the same point. To go to the outer side of this opening would materially diminish the danger of section, but the operator must recollect that the nerve there lies close to the lower border of the horizontal ramus of the pubis. If section is made at a nearer point the body of

the pubis alone will be cut, and, owing to proximity of this line of incision to the symphysis, the special advantage of the operation over symphysiotomy will be measurably diminished. The best point for section is probably about two and a half inches from the symphysis. The direction of the section will be downward and somewhat inward, the chain saw cutting first the traverse and then the descending pubic rami. Of course the obturator nerve can be avoided by careful adjustment of the saw about the transverse ramus.

*Pyrexia in the Puerperium.*—Advanced notions concerning the treatment of puerperal pyrexia have been maintained and strengthened. I have frequently seen the temperature in the puerperium run up to  $103^{\circ}$  and  $104^{\circ}$  for a few hours and then subside under the influence of simple remedies, and therefore great haste in the matter of operative interference is by me non-countenanced. But when the temperature is disposed to remain high, or when there is a decided rigor at the beginning of the pyrexia, with no explanation traceable to disturbance distant from the pelvis, little time should be allotted to the expectant plan of treatment. First of all let the vagina be washed out with a gentle stream of hot boiled water. If the symptoms do not improve within a few hours, or if the temperature is only temporarily lessened, the uterus should be carefully washed out with plain boiled water, ample provision being made for return of the fluid. Then seizing the cervix with a pair of bullet forceps and drawing it downward until it is within easy reach, the uterine cavity should be wiped out repeatedly with pledgets of absorbent cotton or iodoform gauze. If this should fail to give more than temporary relief, the organ should be curetted and packed with either iodoform or sterilized gauze, the end of the strip being allowed to trail into the vagina for drainage purposes. If up to this point the manipulation has been done with due regard to asepsis, the packing may safely be left twenty-four hours,

and subsequently renewed if required. It may be unnecessary to say that all this manipulation would better be left undone unless it be done with strict regard to perfect cleanliness. A thoroughly clean vulva and vagina and uterus are absolutely essential, and the fingers of the operator, the instruments, and the packing material must be above suspicion.

If at the end of twenty-four hours after packing the temperature does not approach normal, and the other symptoms do not evince corresponding improvement, we are left to infer that the cause of the disturbance, while originally within the tract which has been thus treated, has now located itself within the lymphatics, the veins, the tubes, or has invaded the peritoneal cavity. When this is true some practice laparotomy without delay, but, in view of the results of such operations as shown by reliable statistics, I would still withhold my hand for a season, meanwhile hoping to obtain from our deep-acting remedies results unlooked for by old-school practitioners. This relegates laparotomy in such cases to the place of a *dernier ressort*.

*Episiotomy*.—I am convinced from what I have seen and heard that the operation of episiotomy is far more commonly used than formerly. About three or four years ago I appealed to several of our prominent obstetrical practitioners for their experience with the operation, and was surprised to find how few had become familiar with it in a clinical way. At the time I had resorted to it a few times, but of late I have had rather frequent recourse to it.

Whereas it was my former custom to make several small incisions on either side of the vulva, I now make but one on each side, and that of sufficient depth to give the needed circumference. The authors who mention the subject at all, usually advise that the incisions be made with a knife, and that we leave the integument intact, or nearly so; but this is not my practice. When the perineum is bulging,

and the vulvar circle is tense, with every certainty of laceration, I slip the scissors under the thin margin, and cut outward and backward from half to three-quarters of an inch. By this means the vulvar circumference is greatly augmented, and the perineum is saved. After delivery of the secundines I put two or three catgut sutures into each wound, and the result is usually a perfect vulva. I confess to a partiality for this operation, and have yet to meet the case wherein I have had occasion to regret my resort to it.

*Immediate repair of parturient lacerations.*—The demand for immediate attention to lacerations involving the vulva and vagina is becoming more imperative, while some teach and practice immediate suturing of the even cervical rents. Surely the time is ripe for declaring that the accoucheur who fails to suture vulvar rents is guilty of gross neglect. Nor should one be allowed to escape censure under the plea that anything short of an extensive laceration is not reckoned by him as a laceration.

Suture of such wounds must be thorough, since otherwise the operation will prove unsatisfactory.

*Asepsis.*—Essential progress is being made by the great body of obstetric practitioners in the direction of thorough cleanliness in midwifery practice, but there is still much room for reform in this direction. The slackness of many accoucheurs is truly appalling. Filthy instruments and filthy fingers appear to be the rule rather than the exception. Both students and practitioners need education along this line.

## PUERPERAL FEVER.

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BY

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EACH journal that has been placed upon our desk during the last six months has told us of the World's Homeopathic Congress, and now we are reminded that the eyes of the physicians of the world are upon us, and that they are asking why we homeopaths are given this special auxiliary Congress. The answer must come from us, and if we fail to express here our distinctive opinions, and to show, with reason, what we do as a distinctive school, we can no longer lay claim to distinctive rights and privileges.

Our school has added so much that is original to human knowledge that we can by right appropriate whatever is of value to science wherever found, and by virtue of our law can cast off and discard whatever is worthless in the realm of therapeutics, the science in which we lead.

With this introduction we wish to call attention to puerperal fever, a disease of especial interest to us as obstetricians, not only because of its reputed fatality, but also because of its various ætiology. The physician who masters the history, cause, progress, and results of this disease has a general knowledge sufficient for, and is equal to the discussion of, any febrile disorder. This statement is not surprising, when, as an accepted definition, we state that puerperal fever is any continued fever occurring in connection with childbirth.

The history, briefly given, is first traditional, Rachel's death being attributed to that cause. Hippocrates describes isolated cases. In fact there is no doubt that the disease has made its ravages during all ages, though it was



not recognized as a positive epidemic fever until lying-in institutions were established. After their establishment when records were more complete, we have it appearing in epidemic form, always with some years intervening, and traveling over the world, thus: In 1750 in Lyons, in 1760 in London, in 1765 Copenhagen, 1767 Dublin, in Germany 1770, etc.

During these epidemics it raged with such intensity that the death rate rose in Vienna, as late as 1842, to almost sixteen per cent. of the women confined. The point to be noticed here is that the disease occurred in the form of an epidemic as well as a sporadic disease. An old writer, from whom we have learned much, divided diseases into sporadic and epidemic. According to that writer, sporadic diseases are those engendered by meteoric or telluric agencies, to the morbid influence of which only a few persons are susceptible at a time.

Next to this class come the epidemic diseases, which attack many persons at the same time. They arise from the same cause, and individual cases resemble each other. These diseases usually become infectious when they pervade crowded districts.

The disease in question in its manifestations falls under these definitions, the author referred to is our revered Hahnemann, and there is between the lines of these definitions all that our scientists of to-day have developed.

In 1847 Semmelweiss observed that in the wards in Vienna where the physicians attended the more fever cases occurred and the mortality was greatest, while in those wards attended by midwives the mortality was comparatively small. In the first wards medical students were allowed to examine the patients regardless of their previous occupation, whether in the dissecting room or in the surgical ward. As a result of these observations Semmelweiss advanced the doctrine that puerperal fever was the result of the introduction of a poison from an external source.

Simpson and others in 1850 claimed, and proved to the satisfaction of many, that this fever was identical with surgical fever.

Note here that the physicians and medical students were important factors in the propagation and spread of the disease, and also that it did then, as it does now, come from the introduction into the system of decomposing animal matter. These statements in brief give the history of the disease under discussion. Time will not allow us to do more than announce our conclusion as to the ætiology of puerperal fever.

First. We believe that there is sufficient evidence for believing that it does occur in the form of an epidemic. When in this form it is contagious and infectious, and it should be placed among the miasmatic-contagious diseases. This is the disease of which Noeggarath isolated the germ. This germ may enter the body through the lungs, stomach, or vaginal tract, it may be introduced prior to confinement and lie dormant, not developing until after delivery. We are all justified in being guided by our experience, and in forming our conclusions in accordance therewith, and we must not ignore evidence from reliable sources. We believe that we have seen a specific form of puerperal fever.

We know that each year many of us have cases of cholera morbus, cholera, or severe diarrhea which present the symptoms of cholera. Some of these are fatal, and there is no way of distinguishing by symptoms between our cases and those of true cholera excepting that they are single, and that they do not appear in epidemic form. True, the microscope gives us a test, but how many of us use it, or can use it? We believe that cholera does occur in the form of an epidemic, individual cases presenting the same symptoms, and that under these circumstances it is infectious and contagious. Few of us have had personal experience with epidemic cholera. Because many have not had expe-

rience with puerperal fever in epidemic form, there is no reason to deny its existence in the face of the history we have.

This form of puerperal fever is contagious in the highest degree. No physician should take other cases of labor while in attendance upon a case of puerperal fever of this variety.

Second. Physicians, students, midwives, or nurses can infect our patients and so cause puerperal fever. When so infected it is by reason of the introduction of decaying animal matter, or the ptomaines produced during the progress of another diseased condition.

Pregnancy presents a physiological condition which tends to hypertrophy. The puerperal state is a physiological condition tending to atrophy.

After labor as the result of hemorrhage, shock, more or less laceration and traumatism, the patient's vitality is at the lowest ebb. Consequently she is susceptible to disease, and the patient is in a peculiar state, which peculiarity we can hardly describe. She is exposed to the above described dangers. It is rational also on evidence, to assume that germs which would under other circumstances be harmless, are now poisonous, so that the danger from infection by her attendants is greater than under any other circumstances when the physician is called upon for assistance.

Any interference with the physiological condition of atrophy may cause an auto-infection. This is especially true when traumatism is introduced as a factor. When, under any circumstances, traumatic influences arrest circulation completely, or are of such a character or extent to render its return impossible, we have fever, the danger of which depends upon the extent of the injury. Ordinarily the inflammatory condition remains at the seat of the injury, but when in connection with labor it interferes with the process of atrophy, we have as a result a continued fever.

Third. Evidence that we cannot dispute teaches that there is an intimate relation between many cases of puerperal fever and the zymotic diseases, diphtheria, erysipelas, etc. Personally we have been able to distinctly trace three cases directly to diphtheria. One case occurred this winter: a patient who was nearing her confinement period left her home because of the presence of diphtheria. Ten days after she was delivered, and in thirty hours after delivery puerperal fever was announced by the initial chill. Her attending physician had not seen the diphtheria case. Our inference is that the poison lay dormant in her system until after delivery. The symptoms as observed by us, and of the disease as it has appeared among us, are as follows:

The first is a chill of short duration, occurring from thirty to forty-eight hours after delivery, followed by a fever of great intensity. The chills return at irregular intervals, though the fever never leaves entirely. The temperature in true puerperal fever describes a curve of about forty-eight hours in length, the fever rising the first half and declining the second.

We do not consider cases belonging to the last two cases contagious in the strict sense of the word, and the physician using special care need not give up his obstetrical practice because he is unfortunate enough to have one patient so affected.

The patient may or may not present any spots of local tenderness, though there is generally some intolerance of touch over the whole abdomen; single spots of tenderness are more frequently found in the ovarian region.

The patient soon reaches a typhoid condition as regards tongue and bowels, though puerperal fever is generally accompanied by profuse sweating, and there is but little delirium. These symptoms are constant, regardless of temperature, which frequently reaches  $104\frac{1}{2}^{\circ}$  to  $105^{\circ}$  on the first and third days. There is usually diarrhea after the fifth

day, the stools being profuse, yellow, and gushing, often uncontrollable.

The lochial discharge is not immediately affected, but gradually diminishes, and is not especially fetid. The milk either does not make its appearance, or the breasts make but a feeble effort to establish their function.

The duration of the fever under the most favorable circumstances is seven days, reaching its greatest intensity on the fifth, but, if the temperature reaches  $98\frac{1}{2}^{\circ}$  on the morning of the seventh day it will return during the following week; in fact we have seen it return on each seventh day for several weeks after convalescence was fully established.

We base our diagnosis on the peculiar curve marked on the temperature chart, the condition of the lochia, the non-appearance of the milk, and the absence of any localized inflammation. It is necessary to differentiate from malarial fever—with its twenty-four hour curve and previous history, also from the fact that malarial fever diminishes the milk, but does not destroy it—fever and chill from suppression of lochial discharges, by the difference in the head symptoms, which disappear with the return of the discharge, from retro-mastitis; by its later onset and the local symptoms from septicæmia, the result of retained fragments of placenta; by the knowledge on the part of the physician that the placenta was complete when expelled, and the fetor of the lochia. Remember that this condition (septicæmia) is first one of local inflammation; true, the system may become poisoned, but that is secondary. Puerperal fever is a constitutional fever, the poison being introduced directly into the system; the other is local, and the patient's life is often saved by the formation of an abscess. We may also have pyæmia, the result of the absorption of the discharge of an old abscess. The history and later development of the symptoms will allow us to differentiate.

As to the prognosis it is always grave, though in view of

the possibilities of our own *materia medica* we need fear it no more than we would a case of scarlet fever in a non-puerperal patient. I say scarlet fever, because I know of no condition so like it in range of temperature and course, even to the desquamation which sometimes follows puerperal fever.

History and ætiology are the same in all schools; preventive medicine should be; in the case of many diseases, our school offers more than any other.

Recalling the part the physician plays as a cause, what course should he follow as to prophylaxis. One word covers all his duty, to our mind: cleanliness. Cleanliness of the patient's person, cleanliness on the part of the physician and nurse, cleanliness of instruments. Everything that comes in contact with the patient must be in as perfect an aseptic condition as possible. No normal discharge from uterus, or vagina, before, during, or after labor contains any noxious bacteria. Our friends of the antiseptic school insist that we shall use the douche before labor, and in labor long continued; use it during its progress; and are certain for the necessity for the use of the antiseptic douche after labor.

The definition of the term, "homeopathic obstetrician," like that of all others, is to assist women during the lying-in period, the essence of the definition being in the word "assist." If he has followed the above instructions he can, during the lying-in period, assist without fear of causing injury, or fear that he has introduced any poison.

Let me call attention here to the fact that there is as much danger in his placing too much reliance upon the supposed antiseptic properties of drugs commonly in use as there is danger in the drugs themselves to the patient. The natural logical conclusion of the teaching of the antiseptic enthusiast is that the physician can attend more than the case of puerperal fever, if he only uses sufficient antiseptic solution; that he may attend cases of erysip-

las, even take part in *post-mortem* examinations, without danger to his obstetrical patients, provided he uses sufficient antiseptic solution. We see in this the great danger, and would caution teachers not to give too great liberty to their students by expatiating too strongly upon the wonderful power of this or that favorite solution.

There is no analogy in nature justifying the course as taught in most of our colleges. We, after much searching, fail to find any record of puerperal fever among animals excepting when operations have been performed—the terrible doctor again the cause. And should poison have been introduced, what then? Its course through the system has been so rapid that its toxic effect is shown by the chill, the high temperature, etc., while local manifestation of the disease is still insignificant, so that we cannot hope by any locally applied remedies to modify its effects. After the germ has once penetrated the tissues, we soon have constitutional fever, in which the local organs are but slightly complicated. But, doctor, look at the records! True, since the introduction of the antiseptic treatment the disease has been reduced to a minimum, but the prohibition of examination by the students without preparation was stopped at the same time; so was the isolation of patients commenced; so was the care on the part of the attendant physician as to habits first commenced. We claim that there is certainly no analogy in nature for the use of the douche, and no argument further than that puerperal fever diminished after its introduction. The women of the present day have not improved in their “getting up,” by these means, and further I believe that the use of the douche interferes with nature’s methods of repairing the injuries of childbirth. It weakens the tissues, and, unless something has been left behind by the carelessness of the physician, there is nothing that nature has not fully provided for. Again, the douche is advocated to stop the absorption of possibly present poisons.

The same power of absorption is present to pick up the drug; and how homeopaths who certainly believe in the sixth potency, can use any antiseptic solutions and still expect clear cut indications for his remedies, we do not understand.

The oft repeated example of the savage, and of the hard-working woman, is a reproach on the obstetrician more than a sign of weakness on the part of his patients. Let us be prepared to meet diseased conditions when they come, but not cause them; and if our conscience is clear that we have not introduced poison by lack of care, we need not follow any of the fashions of the day. The young doctor is taught that should he use the latest antiseptics, and lose his patient, it was the visitation of Providence and no fault of his. But if his patient should die under other circumstances, he is culpable. Away with such nonsense, and especially by those who have at their command remedies, which, when used under our law, in accordance with the teachings of our materia medica, which seems at times to have been written by inspiration, are far more certain as microbe killers than any of the coal-tar products, and the danger of introducing disease by the obstetrician is far less than of producing disease by corrosive sublimate, added to the hydrant water of the day. That cases have died from mercurial poison is just as certain as that puerperal fever has claimed its victims.

Fortunately, as homeopaths, our treatment does not depend upon ætiology, and whatever may be our opinion as to that there is no reason for hesitation as to treatment. As the result of experience we see no greater reason to fear the result in this disease than in any other severe sickness.

What, I am asked, are the remedies. First of all rhus; I never saw a case where it was not called for sooner or later. So constant has been this experience that I anticipate the condition by giving it in the absence of other



directly indicated remedies, or when the temperature remains stationary, not improving under previously prescribed remedies. I need not before this body recount the symptoms, but will add the warning that you need not wait for looseness of the bowels to appear before prescribing rhus, as has been recommended in many cases of typhoid fever. Among other remedies, of course we have aconite for the characteristic fear of death and restlessness; bryonia when the abdominal tenderness is marked—but this is rarely the case; hyoscyamus for the involuntary discharge of urine and stools; belladonna when the head symptoms predominate; arsenicum for its characteristic pulse and stomach condition. The use of kali carb. has been verified for the yellow gushing stools which so frequently present themselves about the fifth day. Should the lochial discharge become offensive, it can easily be corrected by carefully selected remedies, most likely carbo animalis. We will state here that if there is any reason to believe that there are retained membranes or placenta left in the uterus, the curette is indicated. If spots of tenderness appear on the left side lachesis will help; if on the right, lycopodium. We have known the pain to disappear, not to return, in a very few hours after the administration of these remedies.

Frequent sponge baths are advised, their frequency and temperature depending upon the height of temperature of the patient; the free use of stimulants, in the form of milk punch or brandy and water, and if nausea is present, champagne. These indications are the result of experience. I can imagine someone saying that we should not have had so much experience; had the doctor followed the antiseptic methods, he would not have seen so much puerperal fever. Let me say for the gentleman's satisfaction that most of the cases which I have seen have been in consultation with other physicians, and that I have never had but one case of the disease in my own practice

at one time. Again the methods which I have used have been uniformly crowned with success.

In conclusion, we will again repeat that we give this as our experience with puerperal fever, believing that it shows that it is possible to treat this disease successfully by strictly homeopathic medicines after the manner taught by our founder; that if it is followed, the patients will be able to return sooner to a life of usefulness, and as a school we have given the patient the advantage of the beneficence of our law. Physicians may ask, Why should we not avail ourselves of the methods generally recommended? Because, if you fail to take advantage of the possibilities of the law, and to give your patient the advantage of the quickest, safest, and most pleasant methods of cure, you are not true to your patient, not true to yourself, and can give no reason for belonging to a school with a distinctive name, or to one which has a special auxiliary congress.

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### PUERPERAL ECLAMPSIA.

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BY

LEMUEL C. GROSVENOR, M. D.,

CHICAGO, ILL.

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**H**APPILY both for the doctor and his patient this disease is of rare occurrence. It is a violent convulsion, epileptiform in character, followed by coma, occurring during the latter months of gestation, and during and after labor. Although it is a condition of great peril to both mother and child much can be done in the way of prevention, alleviation, and cure.

Many are the causes which in the past have been assigned for this malady, but later research narrows them down to two or three. All causes sooner or later refer to a func-

tional or pathological derangement of the kidneys. Is it pressure of the gravid uterus upon these organs? Is it pressure of the gravid uterus upon the solar plexus, thus interfering with the renal nerve supply? For the renal plexus receives a large part of its nerve fibers from the solar plexus. Is it some peculiar position of the fetus *in utero*? Is it the non-elimination of the uric acid—thus constituting uræmia? Is it albuminuria? The fact that albumen is so constant a factor would lead us to think so. For fifty years albumen has been associated with this disease as its cause and has been so attributed by many noted authors.

But the other fact that eclampsia occurs in cases where little or no albumen is present makes us look for still other causes. I think we shall find them, as my friend Dr. Tooker once suggested, in the peculiar nervous tendency of certain expectant women.

Some have attributed it to anæmia, especially cerebral anæmia; but the gestating woman is a good feeder, and if eclampsia occurred where long nausea and vomiting had been of daily occurrence and the system been depleted, we might then regard it as a cause.

That renal insufficiency through pressure upon these organs may be the cause receives color from the fact that eclampsia occurs in male and twin pregnancies and in persons of contracted pelvis—the male child being on an average larger than the female; for in one hundred cases each of consecutive male and of consecutive female births I found a difference in weight in favor of the male of from one-fourth to one-third of a pound on the average.

That it occurs in primiparæ, and especially in elderly primiparæ, is evidence in the same direction; for this first distention of the abdomen causes more resistance and pressure—and when these abdominal parietes have settled down to mature life without distention, as in the elderly primiparæ, the resistance is still greater.

That these attacks are due to pressure, in part at least, is supported by the fact that prompt delivery of the child—thus removing this pressure—prevents, in so large a number of cases, a recurrence of the convulsions. If we are correct in the premise that pressure is a prime cause, then we can deduce our prophylactic hints.

*Hints.*—1st. Easy habits of dress, discarding the corset and the bands about the waist, thus relieving the tension here.

2d. A semi-prone position in sleep, the abdomen resting upon the couch and not upon the kidneys.

3d. Daily massage of the abdominal parietes, using warm sweet oil in the process.

4th. In the rare cases where peripheral irritation causes the convulsions—remove as far as possible all sources of irritation. These, with a proper affiliation of remedies like arsenicum and apis, will prevent the final trouble in a large majority of cases.

*Symptoms.*—Among the first symptoms noticed are: a puffiness under the eyes, specks of cobwebs before the eyes, sounds in the ears, swelling of the feet, ankles, and also of the wrists.

These symptoms should lead to an immediate examination of the urine, and if we find albumen present in any considerable quantities we should immediately commence our preventive treatment. Our armamentarium is full, complete, and effective to combat this state of things.

My friend, Dr. Tooker, the eminent professor and author, once met me and said he had a case which promised convulsions at labor, having all the symptoms that precede eclampsia. He urged me to respond promptly if I were called to his aid. A proper affiliation, however, of the remedies in his skillful hands prevented, and he told me later that she passed through the ordeal of labor safely. Perhaps no agent is so valuable at the time of the convulsions as chloroform wisely administered. It has held many

a case in check while the true remedy was doing its curative work. Perhaps belladonna and opium are the most commonly indicated remedies. It seems strange that two remedies so diametrically opposed to each other should be so happily and uniformly efficient in this disease.

*Some Consultation Cases.*—Dr. S. N. Snider called me in a case of eclampsia. He had delivered the case and hoped that this would terminate the convulsions, as it so frequently does, but they continued, and were of a violent and alarming character. Chloroform held them in check while the belladonna was doing its work. This case made a good recovery.

Professor Tooker called me in another case, which was sprung upon him without his previous knowledge of the threatening. The lady was in a series of frequently recurring convulsions when I arrived. It was a primipara past thirty years, with a breech presentation—the breech having been for some time impacted in the straits. Some convulsions occurred after the delivery, but under Dr. Tooker's skillful handling of the remedies she made a full, though tardy recovery. Later she moved west, had another child, and died of puerperal convulsions.

Some months ago I was hastily summoned to an adjoining State. Here I found a lady thirty-seven years old, seven months along in her first pregnancy, and having had frequent convulsions for some weeks. There was evident and increasing harm to the sensorium from the long continued strain. After getting a history of the case, I advised an immediate termination of the gestation as the only course offering any hope of relief. In this view the two physicians in charge and also the family acquiesced. At 11.30 P. M. I commenced by dilating the os, using first an index finger, and then two index fingers back to back. Soon I had sufficient dilatation for the application of the forceps. The labor terminated successfully in three and one-half hours. The lady had no more convulsions—regained con-

sciousness—and the doctors in charge wrote me three days later that they had strong hopes of her recovery. She died about two weeks later as I afterward learned. And right here let me say that if this renal disturbance is from pressure of the gravid uterus, we have a right to expect relief when that pressure is removed—but if the convulsions arise from an old Bright's disease the prognosis is very doubtful.

*My own cases.*—In my own practice I have had but four cases with two deaths in a thirty years' practice covering between three and four thousand cases. The statistics and authors would lead us to expect one in about five hundred cases, but my experience has been much less. I think that by early recognition of the danger, and a proper use of our homeopathic remedies, I have been able to prevent several cases.

1st. My first one occurred about twenty years ago in the case of Mrs. H., a primipara. The convulsions occurred every thirty minutes. After the second I sent for Dr. S. P. Hedges in counsel. He being out the messenger brought Dr. M. The lady was delivered with instruments, when the convulsions ceased, not to return, and the lady made a good recovery. The convulsions did not return at subsequent labors. She is at the head of a beautiful family to-day.

2d. Mrs. S., from another city, was placed under my care, expecting to be sick in six weeks. She was a primipara nearly thirty years old. Her eyes were puffy, her hands and limbs were swollen, there were specks before the eyes, also sounds in the ears, occasional vertigo, and frequent micturition. Asking the husband to call at my office, I had an opportunity to tell him of the danger and that he must be prepared for trouble, explaining to him as definitely as possible what the dangers were. When within two weeks of her expectation I was hastily summoned, to find her in convulsions of the worst type. They continued at frequent

intervals for about eight hours when, with a violent convulsion, the trouble ended in death. She was unconscious from the time she was taken, never rallying a moment. My nephew, A. Grosvenor Thome, assisted me in caring for the case.

3d. Was called to Mrs. P., aged thirty-three years, who had lost all her children a year previously with diphtheria. She had it in a severe form herself, losing some features of her face by blood poisoning as her doctors affirmed. This diphtheria probably left a kidney disease which fatally complicated her gestation—for when about eight months along she was taken with eclampsia, and died in a convulsion the next day. My son, Dr. Lorenzo N. Grosvenor, was with me in the case. Whether this case should be regarded purely as a case of puerperal eclampsia or as a sequela of diphtheria is a question.

4th. Mrs. S., December, 1892, a German, primipara, large and strong, and twenty-four years old. When the confinement engagement was made there was some indications of kidney trouble, but the family being poor objected to what they called unnecessary visits. I was called about seven in the evening but found her only skirmishing, and went to another labor case. At twelve I left my case and saw her again, this time leaving my assistant, Dr. Wallace F. Grosvenor, in charge until I should complete the other case. Toward morning she became tired, fretful, and nervous. At 6 A. M. she had a severe convulsion, and they occurred hourly until 8 A. M. My son gave chloroform immediately and held the case well in hand until 8 A. M., when I applied the forceps at the superior straits and labor was terminated in about thirty minutes. Convulsions followed at 9 A. M., 12.30 and 5 P. M., and during the evening she had three more, the bell. and the chloroform holding them in check somewhat. I then prescribed rectal suppositories each containing ex. bell.  $1\frac{1}{4}$  gr. morphia sulph.  $\frac{1}{4}$  gr., to be placed every three or four hours.

She had two very nervous and sleepless days, when she commenced to gain and made a rapid and perfect recovery, being up and about her house in two weeks. The child was a female, weight  $10\frac{1}{2}$  lbs., strong and healthy.

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## PUERPERAL INSANITY.

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BY

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PUERPERAL insanity is commonly divided into three varieties: 1st. Insanity of pregnancy, appearing during the term of gestation. 2d. Puerperal insanity proper, occurring soon after delivery: and 3d. Insanity of lactation, occurring during or after the continuance of prolonged lactation.

In my belief the first and last of these varieties should not be classed as puerperal, as they are usually due to some cause other than the puerperal state, which latter stands in the relation of precipitating cause only. There is an inherited predisposition, neurotic or hysterical foundation, syphilitic taint, or an exhausted devitalized state, and the puerperal state is no more an ætiological factor than any non-puerperic cause of exhaustion, mental or physical.

The second variety, or puerperal insanity proper, occurs more or less suddenly after a recent accouchement, and is a septic condition. It is most always maniacal in type, especially if accompanied with much elevation of temperature and the other symptoms of septic intoxication, while those cases (decidedly in the minority) which take on the melancholic type are the outgrowth of a less active involvement of the system with the septic poison, and accompanied by the usual symptoms of asthenia.



In the cases of pure puerperal insanity that have come under my personal observation, there has been no doubt of the septic origin of the disease, as evidenced by the condition of the sexual organs, the veins, the breasts, the development and course of the symptoms, the reading of the thermometer, and the other evidences of septic absorption.

The following two cases will illustrate the two types:

Mrs. N., age thirty, multipara, nervo-sanguine temperament, delivered with forceps after a tedious labor, did well until the fifth day, the night following which she was restless and did not sleep, temperature on sixth day  $101^{\circ}$ . Became possessed with the delusion that another child had been substituted for her own by the nurse, with collusion on the part of the attending physician, upon the entrance of whom into her room she would develop paroxysms of intense excitement, although toward the nurse she maintained a tone of imploring entreaty, as though she might in this way induce her to restore through pity her own babe.

Examination showed a diphtheritic inflammation of the vagina, the womb was enlarged somewhat and not particularly tender, but much pain along the course of the saphena veins in the thigh was complained of. Her temperature for a period of four weeks was often up to  $103.5^{\circ}$  and was rarely below  $100^{\circ}$ , at which times of depression there was distinct sweating, once or twice profuse. She made good recovery at the end of three months under antiseptic treatment and the indicated remedy.

CASE II. Mrs. K., age thirty-five, multipara, was seen by me with a brother practitioner. On the sixth day after an easy and natural labor she complained of chilliness, aching in the back of the head, limbs and lumbar region, temperature  $100.5^{\circ}$ , milk rather scanty and patient much depressed thereat, fearing that she could not sufficiently nourish her child. This fear became so fixed that in a few days she

talked of it to anyone who would listen to her. She became dejected, lachrymose, and despondent, declaring that God was punishing her by depriving her of milk for her babe, because she had not desired it, and had striven in the early months of her pregnancy to procure miscarriage. During a period of three weeks her temperature ranged from  $97.5^{\circ}$  to  $101^{\circ}$ , no regularity in the remissions. She perspired much, and there was an unwholesome and sickly odor about her person. Examination showed slight laceration of the cervix and peritoneum, a single stitch having been taken in the latter at the time of delivery. There was an offensive lochia, not profuse in quantity. She became very morose, refused food, expressed a desire to die, and needed to be watched constantly that she did not execute the threats of suicide which she constantly made.

She made recovery after persistent treatment consisting of antiseptic measures at first, the indicated remedy, enforced feeding, with careful nursing.

Both of these cases were clearly septic in their origin. There was no albumen in the urine of either. There was a history of insanity in the family of the first patient. In fifteen years' experience I have seen eight cases in the acute or early stage, either my own or in the practice of friends, that in my estimation were septic. I have seen a number of others brought to Atlantic City for the benefit of the climate, most of them, of course, several weeks or months after delivery, and many of them, in my belief, not puerperal at all, but in whom the puerperal state had been a precipitating cause.

It follows from this: First, that true puerperal insanity is septic or ptomanic in its origin; second, that the prognosis based upon this belief and the following out antiseptic measures is much more favorable than ordinarily laid down; and third, that prophylaxis is of the utmost importance.

As to treatment—I advise quiet, rest, and freedom from

care, absolute cleanliness of the person of the patient, the intra-vaginal use of

**R** Hydrogen peroxide.....f ℥ j  
 Aqua. therm.....O j or stronger  
 M.

the use of creolin, hydrarg-bichlor. 1-10,000, permanganate of potass. solution, or simple hot boiled water, etc.

If undoubted indications existed of uterine involvement I would not hesitate to make use of the intra-uterine douche with any of these, particularly the peroxide of hydrogen; and as a last resort, but not hopelessly late, the intra-uterine curette.

I advise careful and persistent feeding, forced feeding, and not of liquids, which in this condition, as in other stages of insanity, is of little avail, a half pound of solid food being of more value than many quarts of liquid nourishment. As to remedies—we have many valuable ones, and while each case will require careful study, comparison, and selection, I may be pardoned for calling attention to a few of those perhaps not so well known, that I have found of value.

*Hyoscyamine*.—Hyosc. hydrobromate. These have been of much value in the maniacal form, in substance and in potency, and of particular value in many cases in procuring sleep, working admirably in a case where morphia and chloral had failed utterly in the hands of an old school friend.

*Valeriana*.—Mother tincture in water. This is particularly indicated in excitable, hysterical cases.

*Scutellaria*.—This drug is indicated in the melancholic variety with marked depression, nervous exhaustion, apathy, and characterized by frequent changing of the phase of the symptoms.

*Monotropa Uniflora*.—This remedy is of essential value in cases exhibiting great erethism accompanied by disturb-

ances of the sympathetic nervous system, as dyspnœa, rapid and vasculating pulse rate, vaso-motor disturbance, etc.

*Ammon. C.*—One of the best remedies in the maniacal type, to be thought of also if the case should present any albuminuric complications or uræmic phenomena.

Of course it is of little use for me to speak here of the value and indications of such well known remedial agents as bell., stram., lachesis, arsenic., aurum., phosphorus, ignatia, stannum, zinc, sulphur, etc. Very few cases would be successfully treated without their use.

To summarize, then—the treatment that I would recommend would be asepsis (prophylaxis), antisepsis, forced feeding, the indicated remedy, and hygiene.

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Mrs. B., twenty-two, married and pregnant with the first child. No inconvenience was noticed during the pregnancy. Labor began and was progressing nicely, vertex presenting, right occiput anterior, cervix dilating well, and everything appeared favorable until the head reached the hollow of the sacrum, where it embedded itself, and all efforts to dislodge the same were fruitless.

As the cervix was soft and well dilated I ruptured the membranes and decided to apply the forceps, rotate the child's head, and, if possible, deliver a living well-formed child, but what was my surprise upon applying the forceps and locking them to find the worst case of uterine hemorrhage that it has ever been my lot to see. The blood poured out in a perfect torrent, and in less time than it takes to tell it the bed was covered with blood, which soaked through two mattresses and dropped upon the floor.

Carefully removing the forceps, I endeavored to find the cause of the hemorrhage, but being unable to do so, I reapplied the forceps, (the hemorrhage meanwhile becoming more and more profuse) and forcibly rotated the occiput, delivering the child, which was somewhat asphyxiated, then removed the placenta, and gave the woman one teaspoonful of fluid extract of ergot. The uterus quickly responded to the remedy, and in a few minutes all of the hemorrhage had ceased.

The mother had a slight chill, but otherwise made a good recovery; was able to sit up at the end of two weeks, and is now in excellent health. The child (a little girl) was well formed, weighed about ten pounds at birth, and was not injured at all by the forceps.

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## SCARLATINA IN THE GESTATIVE AND PUERPERAL STATES.

BY

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OF all the varied zymotic maladies possible to the gestative and puerperal states of woman there is none more obscure in its ætiology, ambiguous in its symptomatology, or problematic in its diagnosis, or more freighted with peril in its issue than scarlatina, which has been chosen as the theme of this brief paper. Scarlet fever may attack either the gestative or the puerperal state. We will consider the subject in this order :

### I. As declaring itself in the gestative state.

If the exposure to the infection has occurred in the early months of gestation the attack follows not much beyond the average period of incubation in the non-gravid state, and predominantly is inductive of abortion. That this should occur doubtless depends on two causative conditions: one is the exceedingly high temperature, either in adult life or childhood, and this alone would very surely compromise embryonic life ; and another is the doubtless

direct toxic effect of the virus on the embryo, for it admits of no question that the embryo becomes infected through the virus, of which the mother's blood can be the sole bearer.

The attack is inaugurated almost universally with a severe chill and, with or without more or less severe anginal symptoms, early declared fever ensues, characterized by exceedingly high temperature, carrying the mercury up to  $103.5^{\circ}$  Fahr. to  $104^{\circ}$  and  $104.5^{\circ}$  Fahr., and all this within the period of twenty-four hours. In cases anginal symptoms accompany, the attack is more often imputed to cold, so called, or some special and extreme meteorological changes. The fever will rage on hardly longer than thirty-six or forty-eight hours, when abortive phenomena ensue, with a declared rash on face, hands, and arms. The discharges from the womb soon become tainted, either patent or detectable only on close observation. The rash runs down over the body, and limbs, and feet, not uniformly in one unbroken blush, but in detached areas. As the rash extends, the febrile phenomena continue with increased intensity, complicated and blended with the metritic irritation and distresses of the abortive act. The intense blood heat, the thirst, the dry tongue and mouth, the burning or stinging or itching rash, the uterine suffering, the offensive discharges, lochial or otherwise, the vigilance and restlessness, and more or less delirium make the case extreme and critical. Here will arise, if not before, the problematic question of the greatest import. Is this rash, faintly outlined it may be, and occurring not in a continuous blush, but in detached areas, zymotic from scarlet fever infection, or is it the skin discoloring of septic poison? Is the case, in brief, one of zymotic or non-zymotic puerperal fever? There is demanded the most searching and exhaustive inquiry into the history of the patient and family, with the view to determine the exact provocation of the attack, whether it was autogenetic or heterogenetic. For this

infection may have run through very circuitous and unexpected routes.

Apart from the presumptive evidence of a clearly defined tracery of exposure to scarlet fever infection, there are points of differential diagnosis that will contribute to the solution of the problem.

1st. In scarlet fever infection the onset and progress of the puerperal fever are more violent, and carry a higher average temperature.

2d. The anginal symptoms, if any accompany the case, are more extreme than what pertains to a non-septic sore throat.

3d. The tongue becomes red and dry much sooner and more papillary than in septic fever.

4th. The rash rarely appears until after the abortive act is completed, so far as the embryo is concerned, but appears earlier than the rash of septic infection would declare itself.

5th. The rash or skin discoloration is a frequent rash, and closely examined is found more diffused and miliary in character, which is not true of septic staining of the skin.

## II. As to declaring itself in the puerperal state.

If the exposure to scarlet fever occurs in the later months of gestation, the infection may remain and is prone to remain a latent, dormant force until labor at full term is declared and completed, but immediately thereafter will burst forth in form of a declared puerperal scarlet fever. This incubation may have an extension back away to the seventh and a half and even to the seventh month, and give no evidence whatever of itself for this protracted period, as has occurred in a case of recent experience of mine. The mother had been called upon by a neighboring friend at the date of her gestation, whose sister, very ill with scarlet fever, she had visited and nursed. This was, in her case, the only possible source of infection, as was determined by the most searching inquiry. For nearly two months the infecting virus had remained dormantly incuba-

tive, and manifested its true character not until twelve hours after delivery, when there was first noticeable a rash on the mother's face, which gradually extended to her neck and throat, arms, wrists, and back of hands, and in twenty-four hours the entire body became stained with the rash. The fever was inaugurated with the rash, and intensified with its extension, carrying the temperature to 104.5° Fahr. in twenty-four hours, with all its ordinary phenomena. No anginal symptoms appeared. The itching and burning of the skin was extreme. Her lochia became exceedingly tainted; her milk fully formed but rapidly disappeared, though partially returned after established convalescence, which took place at the expiration of the middle of the second week. On the morning of the second day her babe, fair of skin at birth, showed the same rash phenomena with the mother, and became covered from head to foot; its fever gradually increased as the rash progressed. The babe survived, and became convalescent soon after the mother's restoration to normal temperature. The exfoliation in the two cases exceeded anything I had ever before seen.

The problematic question in this case was, What was this fever? Was it septic or zymotic? Here was a woman apparently perfectly well at the close of her gestation, and whose labor was primiparous and every way natural, at the end of twelve hours gave evidence of febrile symptoms and whose face showed stains of rash, and at the end of thirty-six hours carried a temperature of 104.5° Fahr., whose lochia became checked and very offensive, and whose breasts collapsed with entire loss of milk. Anxiety and alarm gathered around the case, and the matter of diagnosis as well as prognosis became serious and embarrassing. Reliance was put upon the diagnostic points before made, but one of the factors was wanting. There had been no conscious exposure. Not until several days after the case had been designated scarlatina, were the facts recalled of the neighbor friend's ill-timed visit, while nursing her sister



very ill with the malady. This at once poured a flood of light upon the case and removed all ambiguity.

One object of this brief paper is to awaken a caution, which I am convinced has been too little heeded by the profession at large, as to the exposure of the gestative woman to this very common zymotic malady, freighted as it is with such grave suffering, such embarrassing problems of ætiology and diagnosis, and such imperiling possibilities both to the mother and her embryo or child. Against such exposure the gestative woman should be guarded to the limit of every possibility.

Another object is to bring into prominence the surprising possibility of so protracted and so dormant incubation of the infecting virus, as the full appreciation of this possibility may furnish a key to some puerperal histories that carried to their issue, whether of resolution or death, unsettled questions as to their exact character.

Another object is to elicit expressions of opinions with the view of determining what shall be regarded as indisputable diagnostic evidence by which we can unerringly differentiate between the rash of true scarlatina as affecting the gestative and puerperal states, and the rash that is contingent upon septic poison.

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## THE LEVATOR ANI AS RELATED TO PARTURITION.

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BY

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**T**HERE seems to be a general misconception concerning the anatomical structure and functions of the normal levator ani, and little appreciation of the influence it may

exert on childbirth, and of the accidents to which it is liable.

Being generally disregarded when normal in character, it naturally follows that it is often overlooked when abnormally developed, and the evil consequences resulting from its injury not generally understood.

Enclosing, as it so nearly does, supplemented by the coccygeus, the pelvic outlet, it has been called "the diaphragm of the pelvis."

In most cases it is so thin as to be nearly membranous, its fibers being arranged in flat bundles, loosely held together, with here and there spaces filled with fat and connective tissue. This peculiarity of structure adapts it most favorably to bear the strain and distention incident to childbirth.

The levator ani has its origin in part from the bones and in part from the fascia of the pelvis. Of those portions having a bony origin the largest and more important is that coming from the horizontal ramus of the pubes. This portion, moreover, most interests us as obstetricians.

The anterior edges of this muscle do not meet at the symphysis, but are separated by a space of about an inch. The portion arising from the pubes is at its point of origin about  $1\frac{1}{4}$  inches wide, and its insertion is about  $1\frac{1}{4}$  inches below the upper border of the ramus.

This bundle of fibers is much thicker than the rest of the levator, and its edges are so thickened and rounded as to itself resemble to the touch two independent bundles of fibers. In some cases it becomes so hypertrophied as to give rise to severe vaginismus and dystocia. Following the origin backward from the pubic ramus, it is found to arise from a crescent-shaped line of fascia extending to the ischial spine, whence arises that smaller portion which has a bony origin. The portion arising from this curved line of fascial origin is strengthened by the pelvic fasciæ, the tendinous fibers of which are flattened and spread out upon both its upper and under surfaces.

The course of this muscle is downward and backward and, except a small bundle of fibers, extending back of the rectum. That which passes anterior to the rectum is a bundle of fibers only a few lines wide. It has its origin at that point of pubic attachment farthest from the symphysis, and, crossing the larger belly of muscle in a diagonal direction, is lost in the recto-vaginal septum, about half an inch from the anus.

While usually in women this portion of the muscle is quite small, in some instances it is markedly strong and hypertrophied, as may be proved by careful recto-vaginal examination. With the exception of this bundle of fibers, that portion arising from the pubes, which, as we have said, is the largest, extends as one continuous strip of muscular tissue from its origin on the ramus of one side, down alongside the vagina, to which it is attached by strong connective tissue and by an interweaving with some of the longitudinal muscular fibers of the vagina around the back of the rectum to its point of attachment on the ramus of the other side. Some of its fibers are interwoven with the longitudinal fibers of the rectum, but, as in the walls of the vagina, they do not lose their identity. This band is intimately connected with the sphincter ani, some fibers crossing or interweaving with some of the sphincter fibers which are inserted into the dorsal surface of the coccyx. As the muscle spreads out toward the coccyx, its bundles become flatter and thinner. It hugs the concavity of the curve-end of the rectum and supports it from below. The middle portion joins its fellow by aponeurosis at the point of the coccyx. The smallest and posterior portion is fixed by tendinous attachment to the fourth coccygeal vertebra.

The functions of the levator are primarily to aid in defecation. In woman, however, it has other functions. It draws the anus and posterior wall of the vagina toward the symphysis, and during coitus, as a vaginal constrictor, presses the penis firmly against the *os tincæ*.

In strength it varies greatly, it being found strongest in

women of strong muscular build, of erotic disposition, with wide pelves, and in those suffering from painful lesions around the vulva and anus.

By careful experiment the average lifting power has been found to be ten pounds, while in some it is as high as twenty-seven pounds. There are reported instances of tonic spasm of the muscle during copulation so strong as to require anæsthesia for the release of the imprisoned penis.

This abnormal development and increased strength of the levator is not infrequently called upon to compensate for other defects. A woman past eighty years, while ill from other troubles, complained of piles; much to my surprise I found a complete laceration of the perineum. I had known her for fifteen years as a remarkably smart and robust old lady. She had borne several children, and I could not learn that she had ever suffered from uterine trouble or incontinence of fæces. The womb was certainly then in normal position. The levator was very strong, and so contracted as to draw the anus well forward toward the symphysis, thus perfectly compensating, as far as support to the vaginal walls and womb were concerned, for the destroyed perineum, and what seems more remarkable, had so closed the anus that the loss of the sphincter had caused no inconvenience.

Not long since I examined a patient with perineum gone to the sphincter; she had suffered nothing from want of support to the organs above. As in the former case, the strong levator had so drawn the anus forward as to form a substitute for the perineum. Whether a rectal polypus has been a constant whip to keep the levator in a state of contraction cannot be said. Only lapse of time, now that the polypus has been removed, can answer, which it will have a chance to do, since she can see no necessity for having the perineum restored.

In ordinary cases its dystotic power, when it is not abnormally strong from hypertrophy, may not seem very great.

Physiological relaxation, paralysis from continued tension and from compression, all tend to reduce its opposing power to the minimum. A careful comparison of the levator, re-enforced as it is by firm fasciæ, with the diaphragm, will show that its average resisting power is not inconsiderable.

As before stated, however, we not infrequently find the levator greatly strengthened by hypertrophy. This is the most marked in the anterior portion that has its origin from the rami of the pubes and exerts the most power in drawing the anus and vagina forward toward the pubes. The hypertrophy may, however, involve the entire muscle, or only independent portions of or bands of fibers.

It is claimed that the levator ani usually becomes hypertrophied during pregnancy. Painful lesions in the anus, like piles and fissures, which are so frequent a complication of pregnancy, tend to keep the muscle in a state of active contraction which is promotive of hypertrophy. This condition of the anus, irritated by the pressure from the approaching part, comes in contact with the floor of the pelvis, in other words with the levator ani. Pain succeeds pain, each causing the presenting part to press firmly upon the opposing tissues, but in the interval between the pains it recedes to its former position, no advance being made. The muscles of propulsion, already wearied by long continued effort, meet a fresh and untried opponent. The naturally stronger yields through fatigue to the weaker. The pains lessen in force and frequency. Longer delay places the life of the child in jeopardy, and the hot dry vagina, quick pulse, wearied yet anxious face of the mother, call loudly for relief. Now, or even before this extreme condition has been reached, the very short forceps (Hale's) are the most useful. Being small, with almost no shank between the blade and handle, they can be easily adjusted and often without the knowledge of the patient. Then, if just sufficient traction be applied to pre-

vent the presenting head from receding in the intervals between the pains, the levator is kept in a state of continued tension with such paralyzing effect as to soon cause it to lose its power of resistance, and the delivery is accomplished easily.

If, however, hasty delivery be demanded, anæsthesia should be carried to the surgical degree in order to produce complete relaxation of the muscle and avoid rupture.

In case the anus be sensitive and painful from fissures or ulcers, complete anæsthesia is of vital importance, for, as all rectal surgeons know, putting a sensitive anus on stretch will arouse violent reflex muscular action, which can only be overcome by complete anæsthesia. If this precaution be not observed the levator, being in a state of tonic contraction, delivery will most likely be accomplished with a rupture of the perineum and some portion of the levator ani.

A strong and contracting levator is responsible for many cases of detention of the after-coming head. The body having been delivered the muscle contracts around the neck, retaining the head to the extreme hazard of the child.

Budin reports a case. The body was delivered after much delay by the aid of ergot, traction, and expressio fetus. Forceps finally delivered the head without lacerating the perineum, but the levator was badly torn. No sutures were used, and the result was entire loss of power in the levator muscle.

Cases of most aggravated obstruction have been reported as the result of extreme thickening and shortening of the levator.

Benicke reports a case where such muscular changes had taken place, as the result of long continued vaginismus and contraction, that forceps under chloroform were unavailing and craniotomy was restored to. Cases of this kind must be rare.

The levator may present abnormalities in the shape of

irregular thickening of the muscles, presenting constrictions like tendinous bands.

Revillout speaks of a case where a ring or bridle was found within the vagina which prevented the application of forceps. Believing the obstruction to be a band of cicatricial tissue it was incised. The autopsy showed that it was the levator. She had suffered from extreme vaginismus.

A case, unique as far as I can learn, occurred in my practice. Mrs. S., aged thirty-nine; primipara. Just within the vagina was one, and a little farther up a second sharply defined, constricting cord. They were like two puckering strings, firm and unyielding. The vagina seemed gathered in folds upon them, but otherwise normal in texture and yielding. Digital examination was not only painful to the patient, but made her peculiarly nervous. The constriction was not so great as to in the least interfere with the introduction of the finger, but even slight pressure upon those constricting bands was unbearable. Other than this, labor progressed normally until the head entered the pelvic canal and began to press upon the upper constricting band, when, in the midst of the pain, without warning, she went into a violent convulsion. With the aid of ether and forceps the delivery was speedily accomplished, with no subsequent convulsions. The perineum was ruptured to the anus, the irregular tear extending up the vagina past the site of the upper ring. Sutures were used, but how nearly the repair put the parts in a normal condition I cannot say, never having her under my care since. Some two years afterward, in a distant city, she was delivered of a still-born child, after a hard labor, but without any convulsions.

Lesions of the levator are of frequent occurrence, and are often overlooked at the time, since they are within the vaginal canal and the cutaneous perineum may show no signs of injury, or the laceration may extend through the perineum and up the vaginal canal. A careful examination

will show that beyond the perineum the laceration is more or less ragged and irregular and deflects to the right or left of the median line. When we consider how the levator is re-enforced by the intervening rectal walls and the peculiar interweaving of the longitudinal rectal muscular fibers with portions of the levator, we see that the most vulnerable part of the levator must be just before it reaches this adjunct of strength.

This fact makes repair less liable to be perfect, as the deep sulci so often found on one or other latero-posterior vaginal wall prove. In fact, except the band of fibers unusually small and unimportant, that crosses diagonally the larger belly of the levator arising from the pubic ramus, it is anatomically self-evident that the levator will not be torn at the median line. The torn muscle retracts, and if not discovered at the time of injury, it is not an easy matter to so close the wound as to bring the ends of the lacerated muscle into perfect adaptation, which certainly should be done. If neglected, we have a pocket for the collecting of septic matter, which even the free use of the vaginal douche may not remove. If left to heal by slow granulation, it is usually with a partial or complete loss of power in the levator. Sometimes there remains a cicatrix that is specially sensitive, some nerve filament being so incarcerated in it as to be in a constantly sensitive condition. This may be revealed to the patient and physician only by the educated touch of the examining finger, while it may have been a nidus from whence had radiated neurotic and other troubles for months and years.

Often, we believe, there is a concealed, submucous laceration. There being no break of continuity in the mucous surface, the injury is only discovered by the sulcus caused by the retracted ends of muscles, and by the impaired function.

Not infrequently in suturing a lacerated perineum at the time of accident the wound is not brought together evenly,



and the torn muscle is distorted from its normal line. The circumstances attending the case and the absence of efficient assistance make this result, while to be deplored, in a degree excusable as far as the medical attendant is concerned, and the wonder only is that the results are generally so good. The gynecologist must often come in and undo what has been imperfectly done.

Mrs. —, primpara, as the result of a tedious and difficult delivery, had complete rupture of the perineum and a portion of the recto-vaginal septum. Stitches were immediately inserted. For a few months there was a constant sense of pulling in the parts, especially in walking and in sitting down or rising from a chair. This she came to notice less and less. Hemorrhoids developed. Defecation was somewhat difficult and attended by discomfort in the anus. At the end of ten months coitus had become very painful and was soon unbearable. Nervous hysterical symptoms began to show themselves, and at the end of sixteen months from the date of delivery, when she came into my hands, she was physically and mentally in a most miserable condition.

*Physical examination.*—Externally the perineum seemed fairly well restored with the exception that the vaginal commissure was drawn to the right of the median line. Pressure near the anus and near the os vagina caused a sharp lancinating pain. Within the vagina the perineal wall was a hard uneven cicatricial mass. A line of firm tissue, tensely drawn, extended from the right anterior to the left posterior wall of the vagina and was there incorporated in the cicatrix. It was evidently a portion of the levator ani that, in the suturing of the ragged wound, had become misadjusted. It caused a partial occlusion of the vagina; and by constant traction upon the vaginal wall produced a deviation of the commissure to the right. Pressure upon it caused a sharp pain to extend upward into the pelvis and a sickening feeling in the epigastrium. There

was a stricture of the anus, the anterior wall being hard cicatricial tissue. There was subinvolution, but otherwise the uterus was in a normal condition.

*Operation.*—I dissected out the vaginal cicatrix, thoroughly releasing the misadjusted muscle. Removed sufficient mucous membrane so that when the raw surfaces were coaptated the normal wedge-shaped body of the perineum would be restored. The mucous membranes of the opposing sides were united with a continuous catgut suture, and the denuded surfaces were held in apposition by two deep catgut sutures within the vagina and one silver suture introduced from the perineal surface and encompassing the whole field of operation.

The anus was dilated, the cicatrix removed, and the healthy mucous membrane dissected up like a crescent-shaped pocket, the deepest portion being about an inch, but shallow at its juncture with the integument on either side of the anus. This flap of mucous membrane was then brought down over the site of the removed cicatrix and sutured to the integument. The result has proved satisfactory to patient and surgeon.

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## PRENATAL MEDICATION.

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BY

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THE education, evangelization, and more thorough civilization of the world demand strong, healthy people.

A large percentage of all children born cease to live before the fifth year. Of those surviving, many are suffering from disease which unfits them for usefulness. If by any means we may increase the standard of health among children such efforts make us public benefactors.

The knowledge that we have saved a sick child for its mother brings us great reward, such as follows a brilliant operation; but the consciousness of having aided the mother in developing a strong, well child should bring increasing interest and satisfaction.

When children are well born and permitted to live in good surroundings, having correct diet, dress, and care, medication is uncalled for. It is a truism that every child has a right to thus enter life, but in the hosts as we meet them it is difficult to recognize health of infant or parent. It is well known that perfect health of nerves for the mother insures normal position and presentation of the fetus and makes labor a physiological process.

Humanity as yet cannot all claim perfect health of nerve or development, and we oftener meet an abnormal nervous state which, if continued, leaves a lasting impress upon the child. Many a case of wakefulness or restless, irritable child has no other ætiology. We have had valuable instruction upon "Preparation for Motherhood," but we would not lose sight of the fact that every child has *two* parents, and disease or unhealthful tendency of either or both is of equal importance and should receive medical supervision.

Prophylactic medicine is of the greatest importance. Preserving health is more desirable for the individual and society than restoring health. The writings of Hahnemann reveal his purpose to not only cure disease, but to eradicate the tendency thereto. Following the instructions of this renowned teacher, one may relieve present suffering and also modify the blight of inheritance. After an observation and experience of years, I am convinced that every prescription which corrects an idiosyncrasy, or constitutional disturbance, contributes to a better state of the future progeny.

If it is better for a child when his training begins a century before his birth, how much more perfect will he be when his medication is started at the same time. If such

training and treatment were continued a few generations, every abnormal condition might be corrected and healthy parentage would be the rule instead of the exception. It is no longer considered necessary for woman to suffer the numerous complications of pregnancy, for medical skill is able in a large degree to modify or wholly remove the painful states. It will soon be recognized that medicine should be administered, hoping to benefit the coming child. We can offer no universal panacea for inherited ills or congenital defects, but would call your attention to the marked improvement possible in many cases.

We conclude that potentized remedies will correct anatomical or structural deficiencies from knowing that calcarea carb. 30 given in the morning and sulphur 30 in the evening, two weeks out of each month of pregnancy, resulted in a perfect healthy child where others preceding it had cleft palate or hare lip. Calc. phos. and sul. given as above during seven months was followed by a perfect child, where the former one had spina bifida, talipes, and muscular weakness.

Graphites, lachesis, apis, and petroleum have at different times not only relieved the suffering of pregnant women, but so changed the embryo and developing fetus that the unsightly eczema afflicting former children failed to appear. Tuberculous parents, having one or more children who suffered from acute hydrocephalus, have later received calcarea phos., sil., or sul. during the term, and these children not only escaped the common perils of dentition, but resisted the floating germs of contagious diseases, even the Klebs-Loeffler bacillus finding no habitation. Able writers report instances where one parent contracted syphilis before marriage and the children were classed as premature labors or still births, but they changed the record to that of living children by a course of prenatal medication. While much may be done in way of remedies and diet for rachitis, more may be accomplished by medication

of the mother before the child's birth, giving her health that she will not transmit a tendency to such weakness. Injuries do not develop this malady in a child of perfect health. We may not only give *ante-partum* medication to avoid a repetition of ailments developed in children previously born, as the celebrated Von Grauvogle advised, but by timely attention we may secure health for the first child. We would, if possible, have pregnancy begin with perfect health, physical and mental, of both parents. Human perfection does not exist, but we may strive for it by removing the abnormal conditions as we are permitted. She may not be the greater invalid, but we have more frequent opportunity of influencing the mother's system. Every evidence of disease in her, which is recognized and overcome during its intra-uterine existence, gives the infant increased advantage at birth.

If conception occur where marriage was prescribed as a cure for existing suffering dependent upon inflammation or spasmodic nerve action, we may expect accidents during the term and lying-in for the mother, and many nervous disturbances for the infant. There is a form of infantile paralysis due to injury of the nerves of the brachial plexus caused by stretching of the nerve roots, on account of the position of the head during labor. To one who has witnessed a faulty presentation restored by the action of remedies upon nerves and uterine muscles, this calamity seems to be an avoidable one.

We approve of all sanitary and hygienic influences for the coming mother; would be glad if everyone had daily in unlimited quantities both sunshine and love, for these make her willing to endure and able to meet difficulties; but combined with all these, and greater in power, is the influence of the truly indicated remedy. In physical or mental irritation our *materia medica*, with all its imperfections, guides us to measures which correct for the time. and, if continued, *cure* the disease.

Sometimes, when a woman becomes conscious that she is pregnant, she looks forward to nearly a year of discomfort; then a period of greater suffering ending in death or, if not, a continuance of invalidism, increased burdens and anxiety, without the protection, consideration, and tenderness of her life companion, which reconciles many to endure the inevitable; and in her agony she gives expression to the accumulated unreasonableness of generations of her ancestors.

The mental state varies from a generally unhappy condition to that degree of insanity which makes her hate the coming child, and willing to risk closing her own life to accomplish its death and premature delivery. These deep emotions impress the character of the child she fails in destroying, and more frequently than many know gives bent to the mind of a cruel, hard character, an outcast and murderer. The intensity of the evil may be increased by the united purpose of both parents to limit fetal life. "Some biogenic particle goes astray, and through transmission impresses its moral bias upon the erring offspring."

I have seen so often the action of our remedies remove the feelings of hate, dread, or fear that to me it is evident we need only a closer study of indications and their application to produce a surprisingly improved condition of the moral tone of society.

If half the time and energy spent in visiting prisons and in behalf of ex-convicts were devoted to soothing, making comfortable, and curing the morbid fears of pregnant women, we should have less demand for institutions for the feeble-minded, children's hospitals, reform schools, and penitentiaries.

If we would have health of the whole organism, a well balanced, even character, every organ performing its function, every inclination toward normal conduct, we cannot too early begin the treatment of these morbid feelings. A close study of our provings enables us to see a similar in some of the following medicines, which you will see are

nerve remedies—for these disturbances are neuroses : actea rac., ars. alb., cham., coffea, bell., hys., stram., nux. vom., plat., anacard., magnesia phos., and kali. phos.

Then we should have prenatal medication begin with the birth of the parents and wisely continued until each wife in full development, free from disease, with active brain and moral strength is able to meet wifehood and motherhood, with never a term in the hospital nor attention of surgeon ; until she may feed her own child without poisoning its system or morals, or exhausting her strength ; until each husband shall have brain, nerve, muscle, and lymphatic in such normal action that he will not transmit weakness of character nor seeds of death.

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## THE HEADACHE OF CHILDREN.

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BY

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I THINK that the therapeutic treatment of headache, either in adults or children, is a point where homeopathy has most signally triumphed over old-school treatment. In treating adults for headache we have an instance of the great value of purely subjective symptoms ; and at the same time, we are obliged to run the risk of being led astray by our patient's account of those subjective symptoms. I suppose that the patient who can accurately describe and locate his headache, with all its attendant effects, is even more rare than the man who, in proving a drug, can give a true account of the head sensations produced.

This latter rarity brings about another difficulty, for we have such a glut of head symptoms, under almost every proved drug, that to select a remedy becomes an appalling task.

I have been inquiring into the therapeutics of allopathy in headaches recently, and my allopathic friends tell me that besides the mere narcotics, which they agree with me can only smother the symptoms, they have a few new drugs, which are what they call "specifics." In some forms of headache they have been lighted on "quite empirically," but I note that very pretty pathological theories have subsequently been produced to fit the facts of the success attending the use of these drugs. It will interest us, as homeopaths, to learn from our friends something "new." The drugs are aconite, belladonna, gelsemium, phosphorus, and nitro-glycerine !

In dealing with children we have not the difficulty of the patient's inability to be exact in recounting the symptoms, or to accept our suggestions as to the nature of the pain, if they be only sufficiently expressive of the great sufferings ; but we have the still greater difficulty that our little patient gives us no verbal and personal description at all of his feelings. Where the child is old enough to give us a hint, we find the description generally more truthful than the average sick adult, less exaggerated, and often very picturesque, as in one case I have in mind, where a little girl said her head had "eyes worked with lead weight, like dolly" ; and this weight was out of gear, and scraped inside her forehead !

But as a rule we are forced to depend chiefly upon objective symptoms with children, and I submit that this fact accounts for our comparative non-success in the therapeutics of headache in children ; we are tempted to build too much upon pathological theories ; a fault which is not common in homeopathy, for, on the whole, it is probable that we neglect pathological considerations too much in our therapeutics.

I will not attempt a classification of headaches in children,—such would be only arbitrary and artificial,—but there are some general points which experience has led me to think



of value. I have formed an opinion, perhaps on too slight reasons, that frontal headaches in children are more generally the result of some distant affection, or of a constitutional or blood disorder, while occipital headaches are often local, and more often than not they are ocular, or the result of injuries; hereditary headaches seem to tend to one circumscribed spot, generally unilateral, and supra-orbital or temporal.

One of the most common grounds of error in therapeutics in these affections (speaking for myself) is that of founding treatment upon the supposition that the pain is due either to cerebral hyperæmia or the reverse condition, anæmia. We often meet with children who have headaches accompanied with flushed face, bright eyes, and restlessness, and are usually anæmic, and my experience tells me that these children are not successfully treated with belladonna or aconite; more frequently remedies which are homeopathic to their usual constitutional state, such as ferrum or arsenicum, will prove valuable.

In anæmic children with apparently hyperæmic headaches, it will usually be found that 'hot nourishing food, such as hot milk, or soup, will relieve the pain; whereas in true hyperæmic headache, such a course would perhaps increase the pain.

I think that the examination of the urine will prove valuable in most cases of headache in children; many anæmic children will be found to pass excess of phosphates or urates during their headaches; and we may draw valuable indications for diet from such facts.

I had a very painful case of persistent headache in a child under my care, in which great quantities of phosphates were passed, while the urine was copious. The child was depressed and stupefied, had severe pain over the region of the kidneys, vomited his food, and his face was flushed, with photophobia, he had vertigo so that he staggered. Many remedies were tried unsuccessfully, but the rather

unusual one, helonias, proved curative given in the 6th potency.

Another case I have notes of is, perhaps, instructive : a child of nine years of age, a boy, who had epistaxis with his headaches—but this symptom could not be taken as an indication of cerebral hyperæmia, for the child was pale, and markedly anæmic—he was mentally depressed, the headache was in the vertex, he had palpitation of the heart, and auscultation revealed a mitral insufficiency. Lachesis 12 proved the remedy. I mention this case as an example of the error of taking symptoms which often point to cerebral hyperæmia as always indicating that state in children. I venture to say that we too often look upon epistaxis as a proof of abnormal fullness of the cerebral vessels. In children we can usually afford to neglect the possibility of the bleeding being due to disease of the coats of the vessels, as it may be in adults ; but we should be on our guard and remember that epistaxis in children may be a sign even of constitutional anæmia, or of a passive congestion due to valvular disease of the heart.

What are called “school headaches” bring great responsibility upon us ; we are called upon to advise as to the nature and extent of the education which some children can bear, and, if we decide wrongly, we may do much harm to the children in their future life ; there is a grave responsibility attaching to any man who causes a child to be withdrawn from its lessons and to miss that period of life when habits of thought and memory may be most easily learned ; and, on the other hand, great errors have been made in the opposite direction ; school headaches have been neglected, and the child’s brain powers undermined by suffering, and its normally happy child time rendered very miserable. My experience is that under the modern system of education, which recognizes the facts of evolution in these matters, and leads a child up by gradual steps from play to “play-work,” and so on to exercise of memory and perception by

slight and easy stages, we see less of genuine school headaches, by which I mean headaches which are actually the result of overstrain of brain powers; and yet, children at school do very often suffer from headache; after errors of "cramming" have been eliminated, and all the hygienic surroundings of children at school have been reformed to the modern scientific standard, we yet have too many of these cases to deal with. Our children—of course I mean English children only—are very glad at times to get out of school before the regulation hours, and if they choose malingering as the means to this end, they are clever enough to select maladies which are diagnosed by subjective symptoms only, for obvious reasons; and this kind of school headache is the first to claim our attention.

I would not be so discourteous as to suggest that the American child ever shams, but there are English children in your schools. If these should be frequently away from school with headache, it is sometimes found that it is a headache which comes on very early in school hours; is vague in its situation, and the youngster is able to read books of amusing stories, or engage in other occupations requiring considerable concentration both of eye and memory, without a return or increase of the headache. I have found that isolation from the class in which the child is placed at school and the use of special large type, not interrupting the usual hours of work, is worth trying as treatment here. Children will not hold out for long if they are malingering, when thus kept apart from their fellows.

But the fact that children know that there is such a thing as headache from reading print shows that this is no uncommon form of the affection, and I think that a large proportion of the school headaches are due to eye strain.

Headaches due to eye strain are, I have noticed, more often occipital than frontal or vertex; considerable success in their treatment is gained by simple attention to the general health, but so called "tonic treatment" is never

more than palliative; the headache may be kept away so long as artificial stimulation is kept up, but will return when it is removed. When the child is in exceptionally good health, the headache may be absent, as after the holidays; but as the school term progresses, the trouble returns; in such cases it will generally be found that the vision is apparently normal, unless the child is at the moment of examination suffering from pain; but when tired, or when under the influence of atropine in the eye, the refraction will be found at fault; the child is able under ordinary conditions to produce accommodation by an effort which is unconscious, but in excess of what should be demanded of the child; and, under ill health or prolonged application, this strain is evidenced by headache.

I have seen one case, that of a girl of twelve years of age, who suffered from severe neuralgic pain in the neck, radiating down the cervical nerves on both sides, which was caused entirely by eye strain, and was cured by the use of proper glasses.

I have no doubt that the homeopathic therapeutics of such conditions are well known to all present; but they will be of little avail if the help of properly adjusted glasses is neglected; not *pince-nez*, which sometimes provoke fresh headache in a sensitive child by their pressure on the bridge of the nose, but light-framed spectacles. There are three drugs which I have been led to use, of which the first, acid picric, is perhaps not sufficiently valued; the pathogenesis of this drug points to both the headache and the ocular symptoms; I have used it in the higher potencies, by which I mean from 12 to 30; nitrate of silver and cimicifuga are the other two; these I mention as being possibly outside the general run of headache remedies, and because they have served me well. I used the two latter in varying doses, but the cimicifuga in lower potencies, 3x, or thereabouts.

I think that the headaches of girls at approaching puberty

are becoming more general in our times. The new physical *régime* has not been universally adopted as yet, though in families where it has been practiced from childhood I find less suffering among the girls as menstruation comes on. The cause of a girl's headache at this period of her life is generally well recognized by mothers, who are awake to the necessity of physiological rest at these times. I need not detain you with therapeutics here, but would drop a word to attract your attention to the tendency of homeopathic mothers to have a fancy for *pulsatilla* in all these troubles of their girls; it seems very apt to act upon the ovaries rather too freely, for the tendency in most girls is to rather free loss of blood at the first few periods, more often than the opposite (in my own experience), and *pulsatilla* increases this tendency unduly. *Coffea* and *ferrum* seem often useful.

The "genital headaches" of boys at puberty often cause much suffering, and in all cases of intractable headache in boys, the possibility of approaching puberty should receive attention. Other genital irritations in boys also seem to play a prominent part in causing headache, and in my own experience I have found that *phimosis* is not seldom a cause of headache in boys as it is of many nervous symptoms, and you, no doubt, will all remember cases where circumcision has cured such troubles. I have known, in several cases, the most happy results from circumcision, in boys' headaches.

I will not deal with the headache of febrile states, since our attention in such cases is turned to the fever rather than the headache alone; but there are headaches accompanied by fever, and due to malaria, which are instances of the headache being the main guiding symptoms. I think they are usually intermittent; they are either very vague and general in the locality they affect, or occasionally will be truly neuralgic; the pain being fixed in one or other of the cranial nerves, or, at least, being felt over the surface

where the nerves are distributed, and perhaps the supra-orbital is the most common situation. I think that when a malarial headache, intermittent, and chiefly felt in the supra-orbital region, comes before us, we have the true sphere for quinine to be used homeopathically.

I may, perhaps, be at variance with others when I state that I do not think that true "migraine" is often seen in children. In the case of the children of parents who are sufferers from migraine, we certainly often see headaches, but I find them usually to be coincident with some digestive upset; and the vomiting, if present, to be more often controlled by remedies acting upon the stomach than by such as are chosen upon the cerebral supposition. I recognize that these pathological suppositions are alien to the homeopathy held by many, but I think that in most cases it will be found that a remedy, chosen first on the ground of the totality of the symptoms, turns out, on further examination, to be also the pathological similar.

Still there are cases of headache in children, in which, before the onset of pain, we hear of various warning symptoms, such as flashes of light before the eyes, or sensations of dimness of sight, or in some cases temporary weakness or paralysis of an arm or leg, either motor, or sensory, or both; then the pain in the head, localized generally in a definite spot on one side of the forehead, comes on, and is followed by vomiting; such headaches, if frequent in onset, are probably true migraine, not coincident with dyspeptic trouble, and they may be hereditary. The first point is to eliminate the possibility of eye strain, for this is more frequently the cause of migraine than is sometimes supposed. In such cases of true migraine in children, *coffea* 6, and acid carbolic 12, have served me well.

I need scarcely mention the importance of headache where the pain is felt near the mastoid bones, or round the ear, as indicating ear disease; but I have seen the neglect of timely surgical interference very injurious, in at least

three such cases. The pain is not headache, though generally described as such.

And we must always be on our guard when we meet with serious nervous symptoms, such as spasm of the muscles of the neck and spine, paralysis of muscles, twitchings, or convulsions, in connection with children's headaches; such indications of possible cerebral mischief, tubercle, or tumor are of course known to us all.

Finally, I would note the headache of renal disorder. I would urge regular testing of the urine in all cases of children's headaches; for if, as is sometimes the case, the pain is coincident with uræmia or albuminuria, our remedies will be of no use, unless these symptoms are placed in the front rank when drawing up the total symptoms.

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## ALBUMINURIA IN CHILDREN.

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BY

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**M**Y line of thought for some time past has been turned rather persistently in the direction of albuminuria. At the present time medical opinion appears to me to be in somewhat of a transition stage in regard to the pathology of diseases of the genito-urinary organs. A good many ancient (and allopathic) fallacies have been exposed and dropped, and we, the homeopathists, are building up newer views upon surer foundations; the process will be slow,—it is hardly more than begun,—for the problems to be solved are so very numerous. I have endeavored to look at the subject of my paper in the light of present knowledge only, and not to go one step beyond what that state of knowledge would seem to justify. I have kept rigidly before my

mind, too, the fact that childhood only, is at the present time my sphere, and as a consequence I can only touch upon such points in the general pathology of albuminuria as are within the limits of this restriction. Albuminuria, we know, may be produced in children from a variety of causes; the rarest causation, however, is, I think, due to pressure on the renal veins, but let the causative agent be what it may, I believe albuminuria should always be viewed with gravity. If I might occupy a few moments of time with a hasty review of the physiology of the kidneys, I should be glad, as I think it will freshen our memories and assist us in the discussion of this subject—a subject I am most anxious to have discussed, both here and now; for I am assured that a finer opportunity for eliciting important truths from a conflict of fine minds will never arise.

*Physiology of the kidneys.*—Gaze with a retrospective eye, if you please, and we find that the membranous covering of the internal surface of the secretory cells of the kidney is really a true protective organ, keeping from the protoplasm of the cells any substances likely to interfere with their functions. We remember, too, that this membrane varies in its structure, and the variation is due to the degree of functional activity of the epithelium.

In conditions of repose, this membrane is homogeneous; in conditions of activity it is peculiarly marked, having a quantity of clear streaks running through it and taking on the appearance of a structure formed of small straight rods, these, being together, or separated by an intermediate substance of a clear fluid character. After some great functional excitation a remarkable change takes place; the collected urine detaches and pushes away this membrane from the protoplasm.

The products of the renal secretion collect within the epithelial cells in the form of liquid masses, having either a rounded or elongated appearance, and clear like the contents of the tubules. This fluid percolates through open-



ings in the limiting membrane, sometimes breaking through the latter to gain the interior of the canaliculi, often detaching and carrying it away. A great advance has been made in our study of ætiology, proven by the fact of our knowing that a micro-organismal factor exerts its most prominent pathological influences upon the kidneys. Within the past year or two some notable contributions have been made to the literature of this disease, notably that of Clifford Mitchell, whose able exposition of the relation of urinary analysis to diet is of untold value; of Mannaberg, upon the relation of acute nephritis and the streptococci found in endocarditis. In eleven cases of acute nephritis Mannaberg found the urine to contain streptococci, which disappeared from the excretion with the disappearance of the symptoms of disease. In patients affected by other maladies and in healthy individuals this micro-organism is not to be found, although searched for in a long series of urine. Mannaberg has cultivated the streptococcus in question, and separated it, by peculiarities in its cultivation, from other varieties of streptococci. These do not appear to select the kidneys as an especial position for growth; they probably multiply in the blood and tissues generally, and in their escape through the renal structures produce their serious consequences.

This, undoubtedly, is a form of blood poisoning specially involving the kidneys. As I have before said, a great many old fallacies have been dropped, the trend of thought and study to-day is carrying us still farther and farther from the old lines of thought; views formerly held are either passing into desuetude, or becoming very much restricted, causes of disease, formerly hardly conjectured, are being added to the list, and some factors of causation, such as exposure to dampness, cold, etc., are dropped out.

I might occupy your time by citing almost numberless cases, published both abroad and at home by adherents of both schools, where there is no apparent causation of

renal disease from exposure to dampness or cold. I will merely cite from Letzerich. He observed a number of cases of renal inflammation due to a characteristic bacillus, from cultures of which he could reproduce nephritis in rabbits. The symptoms he found in general similar to those in other cases of nephritis, somewhat mild in form, but showing a predominance of gastric phenomena.

He found the spleen apt to be swollen, with considerable fever, and often rapidly developing œdema and effusion into the serous cavities. The urine contained short straight or curved rods in large numbers; these symptoms, finding no history of exposure to dampness or cold, make the suggestion of a micro-organism exceedingly relevant, especially so, when taking into consideration the manner of onset, the involvement of the lungs, and the prostration accompanying the affection. The affection in question was found most commonly in children, and in cases which came to *post-mortem* section it was found that the bacilli developed only in the interstitial structure of the kidney, and spores were, however, found generally throughout the body. At no previous time has the question of the infectious nature of the renal affection known as Bright's disease been so forcibly placed before the profession, and there can be no doubt whatever as to the prominence which will hereafter be accorded to infectious influences in the production of the malady. An exceedingly interesting and instructive paper, published by Agnes Bluhm, upon the ætiology of Bright's disease, is based upon an analysis of 8442 cases, material derived from clinics during a period of five or six years; and the vast majority of these cases was clearly traced to an infectious origin.

We find to-day a good many men in our own school, besides numbers of outsiders, who still pin their faith to a belief in the constant existence of albumin in normal urine. After having made a great number of carefully conducted examinations of normal urine, I feel compelled to place

myself in opposition to these, the result of my experiments having proven most satisfactorily to my own mind that the presence of albumin is not characteristic of normal urine. There are some of us who argue that small amounts occurring in normal urine tentatively are of no significance; that it is only where it reaches any large proportion that it should be seriously considered. I believe that the smallest possible amount should be viewed with gravity, and that, under any circumstances whatever, albuminuria means some fault of the epithelial covering of the glomerules. Probably Purdy's experience along these lines has been as large as any one man's; he, in a publication of his examinations of urine for life insurance, takes this position: "No applicant for life-insurance should be debarred on account of albuminuria, but the time has arrived for stamping out the idea so prevalent among the profession that the slightest traces of albumin in the urine are of no significance. It has been my experience during the past five years to make a large number of analyses of urine from cases of all sorts, but never once have I met with a single case of albuminuria in which a microscopical examination did not discover some pathological condition of the kidney or uropoëtic system sufficient to account for the symptom. Single examinations have not always returned me the foregoing result, but repeated searching has never failed to disclose pathological evidence, so I have arrived at the conclusion there is positively no such thing as a physiological albuminuria."

Physiological albuminuria, however, is a term which has found so much favor with the profession generally that, whatever the belief may be, the term will in all probability remain in vogue. I believe that albuminuria is many times the product of an incomplete or pernicious digestion, the incomplete transformation of the albumin leads to the production of a relative albuminuria, and from this by very evident steps to true albuminuria. So, too, the various toxic substances from a perverted digestion are

brought to the kidneys, in their excretion producing a like train of events. I think when we are testing for albumin we should select the specimen of urine voided at the time when the patient is most fatigued ; the amount of albumin, as we know, is greatly influenced by circumstances ; then should begin an exhaustive examination for casts, and if we fail to find them when they are actually present, the result must be a serious error in diagnosis.

Since I have insisted upon the entire collection of urine voided within the twenty-four hours, my experiments have proved much more satisfactory to myself and beneficial to my patients. When searching for albumin, I have the child exercise as vigorously as is prudent before voiding urine for examination ; where the case is doubtful, I examine the urine of each micturition during the entire twenty-four hours. I need hardly say that the commonest cause of albuminuria is Bright's disease ; but I do consider it my duty to say that I believe a large proportion of the so-called " physiological or functional albuminurias " eventuates in this malady, unless treated before being allowed to endure for any length of time.

We are to-day familiar with the fact that nephritis is a disease common to childhood, arising most frequently after scarlatina or other blood poison. Formerly it was considered as one of the results of cold, dampness, and drinking habits, its especial province the adult.

The average disease in childhood is acute ; so the prognosis for nephritis, as regards complete recovery, is mostly good. As a mere matter of renumeration we are perfectly familiar with the symptoms of acute Bright's disease—the pallor, the vomiting, convulsions, cough, dropsy, a pulse that intermits, oppressed breathing, scanty urine, with a large percentage of albumin—but individual cases are of most interest just now.

Howard B., a boy aged ten, was placed under my care.

His previous history was good, except for an attack of typhoid fever some nine months previous. The boy was hardly to be called sick (from the time of his recovery from the fever until placed under my care); at least for the greater part of the time; ailing at times for two or three days together, causing great anxiety then, and again appearing to be, and insisting upon the fact of his being, perfectly well. There had been an occasional slight swelling of the lower limbs, a fact to which the mother attached no importance. When I first saw him, he was in bed and the swelling had been on the gradual increase. I found the lad in a condition of extensive anasarca, the action of the heart very irregular. The urine was only a few ounces in twenty-four hours, sp. gr. 1024, full of albumin, and containing granular and hyaline casts. The boy during all this time, a period of nine months of treatment, insisted that he was well. The sp. gr. of the urine rose as high as 1030, and for a period of eight months the albumin averaged throughout from a third to a sixth. From that time on it decreased from one-fifth to one twenty-fifth, and during the last five or six days it disappeared entirely. I began treating by restricting his diet, much to the boy's chagrin, keeping him to milk and water, jelly, bread and butter, sweet potatoes, and peptonized milk toast. Digitalis, and later on, ferrum continually, brought the boy around; since that time he has remained well.

A somewhat interesting case of incontinence of the urine came under my care recently; the patient a girl six years of age. The previous history, according to the mother's statement, was one of perfect health. Application was made for admission to the public schools; the child could not obtain admission until vaccinated; from that time on she was ailing, the entire body breaking out in sores. There was a discharge from the right ear, and back of the ear a superficial abscess. The urine at the time was dark, containing color-

ing matter, and was loaded with albumin. The child was suffering at the time from prolapsus uteri with leucorrhœa. I need hardly speak here of the two avenues for physical examination. There is but one way to treat such cases as the foregoing; by means of combined rectal and abdominal palpation. In the case of the child just mentioned, the belly walls were both fat and relaxed, and there seemed a great possibility of considerable resistance being offered. It was important that the examination should be thorough, therefore I anæsthetized at once. Indeed, I think it advisable in all such cases; the effects are rapid, the duration short, and the resistance slight. The rectal touch is the most certain way of approaching tubes and ovaries to be questioned, and combined with palpation by the other hand on the abdomen is greatly enhanced in value. Rectal and bimanual massage proved very effective in restoring the pelvic organs to their normal tone. This accomplished, the albumin, which heretofore had appeared with the greatest regularity, disappeared. No casts were discoverable; so the altered condition of the urine I considered as due to the altered conditions of pressure in the pelvic and renal circulation. The muscular tone of the patient was influenced by daily application of electricity. China proved very useful here. I had a favorable and uninterrupted action of the single prescription and minimum dose of the single indicated remedy.

This "Hahnemannic trio," I rejoice to say, speaks for itself, without any trumpeting.

We have been accused by the old-school men of never having discovered a single bacillus; shall we ever rally from the thrust, or dare to look a brother allopath in the face again, after being told such a thing as this? and yet, who is specially benefited by knowing that a certain comma bacillus is found in this, or a rod-shaped one in another? We have a law that a particular medicine produces a

definite result; and *that one thing* we have proven to be of more practical use than all the natural history of all diseases combined could ever be.

In cases of incontinence of the urine, treatment must be given with an eye to the cause; the principal causes being the various *motor neuroses*. Many of these cases are exceedingly troublesome; when, however, there is irritability of the bladder, I believe belladonna will prove your friend in almost every instance. In such cases, I believe we cannot lay too much stress upon massage of the bladder, per rectum; it has given me most excellent results, together with a daily salt-water bath, accompanied by a brisk rubbing in the region of the spine. There must, too, in such cases, be a careful consideration given to hygiene and diet; and last, but by no means least, attend to the psychical surroundings.

This may on first thought appear overstrained and far-fetched; I make it a strong point, simply because I have watched the effects on a nervous child of a nurse thoroughly uncongenial; I have seen the same kind of thing obtain in the hospital where children were away from home, everything strange and new; it must be unnecessary for me to say that "powerful emotions" bring an increase of albumin in the urine. And, believe me, you will experience unexpected results frequently, if you turn your attention with vigor toward this one thing. I think, if I remember rightly, our own Dr. Clifford Mitchell lays considerable stress upon this; to my mind it is something to be strongly considered, whatever the malady may be.

I was asked, in preparing this paper, to show the prophylactic properties of homeopathy in relation to my subject. I confess myself almost totally at a loss here; the causes of "albuminuria in children," are many, are unforeseen, and it appears to me quite impossible to treat it prophylactically.

## RACHITIS.

BY

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I KNOW of no disease in the whole list of human ailments more interesting than that which forms the subject of this essay, whether it be considered from a pathological, an historical, or a clinical point of view. Here we have a disease common to all nations, climes, and kindred ; with symptoms, phases, and features that are plainly recognized the world over ; a disease which, while rarely fatal, produces serious and irreparable ravages in the framework of the organism ; which in its advanced stages affects every organ and every tissue in the body ; stunting the growth of the young ; a blemish upon the beauty of the mature ; a serious menace to maternity, from distortion of the pelvis ; a disease whose effects we are powerless to overcome and yet one which is conceded by all authorities to be easily preventible ; such is a brief and partial description of the affection to which I invite your attention. I shall waste no time in describing the features of well-marked cases. Its pigeon breasted, narrow chested, bow-legged victims are common sights in every land, and their clinical history is familiar to every physician. I shall not spend your time either in a discussion of controverted points such as heredity, syphilitic complications, etc., etc.

I desire rather to point out, as clearly as I may, the early symptoms by which the rachitic cachexia may be recognized before any serious damage is done to the organism, and which to my mind have been ignored or treated carelessly by those who have written upon the subject ; and then to give you what my own experience has taught me to regard as a specific means of averting all harm by promptly



arresting the progress of those symptoms, as well as aborting the disease itself.

However we may regard rachitis from a controversial standpoint; however-so-many factors may be considered as entering into the ætiology of a given case, all authorities are agreed upon one point, viz., that one factor that enters prominently into every case is the factor of defective food. It matters not whether the rachitic child has been nursed at the breast or bottle fed, the one indictment that cannot be squashed, the one fact that cannot be denied, is the insufficiency of food supply. In the beginning of every case of rickets there is somewhere a fault that amounts to a failure in the matter of alimentation. The nourishment does not nourish. Some essential element necessary to the economy is either absent or is presented in a form which is ineffective. With a ravenous appetite there is lack of normal growth. With abundance of aliment there is perverted nutrition. Abundance does not satisfy; there is starvation in the midst of plenty. When breast fed children develop the rachitic habit it is usually due to prolonged lactation. In doing so, the necessity of brevity must excuse my apparent dogmatism.

Now there are certain facts regarding lactation that have a bearing on this subject, and these facts are so frequently observed as to be incontrovertible.

First: The health of the mother and the abundance of her milk is not always a reliable criterion by which to judge of its nutritive qualities. In other words, there are many women in perfect health and with an ample supply of milk who cannot successfully nurse their offspring.

Secondly: It is law of nature, to which there are few if any exceptions, that every nursing woman's milk begins to deteriorate in quality after she has nursed from a period of from seven to ten or twelve months, and this deterioration progresses steadily, whatever may be her general health, until she ceases to perform the function.

Now it is a significant fact, that while rachitis is far more common among bottle fed than breast fed children, it still does occur among children who are nursed at the breast, and is very much more common among those who are nursed into the second year. Indeed statistics show indubitably that there is a direct and proportionate relationship between prolonged lactation and rachitis. I know of no accurate means of ascertaining the time when the milk begins to deteriorate in a given case by any chemical, microscopical, or mechanical test.

The time unquestionably varies with different women and with the same woman at different times, but I am satisfied from personal observation that with American women, especially with those living in the large cities, the time of beginning deterioration is, on the average, less than twelve months. In some cases it may occur as early as the fifth or sixth month. As soon as the milk begins to deteriorate the child feels it. The evidences of malnutrition are soon manifested, and to the experienced physician the signs are unmistakable. Its body may still be plump and its color normal. Its bowels may be regular and its appetite unimpaired. It may not as yet show any marked changes in temper or reluctance to being fondled. Long before there are any signs of articular enlargements anywhere; long before there is any development of a "rachitic rosary"; long before there is any flattening of the cranial bones or incipient craniotabes, there are symptoms of unmistakable import, if only they are given their true significance. The first of these signs to appear usually, is habitual sweating of the head while sleeping. Cranial perspiration during sleep, and especially during day-naps, is always ominous. It may not always point to rickets, but it is always due to a dyscrasia.

But the most significant and certain of the early signs of impending rickets is found in the delayed evolution of the teeth, although this has its significance, but to the whole

phenomena of teething. A perfect healthy child should show some of the usual signs which accompany this process, by the fifth or sixth month. If this age be reached and there be no increase of the salivary secretion, no tumefaction of the gums, no irritation of the nervous system, accompanied with suggestive actions pointing to the mouth as its seat; if, in a word, there is no change in the inner contour of the jaw indicative of activity there; and if this condition goes on to the seventh or eighth month, the watchful physician should be on his guard. If, in addition, cranial perspiration is present whenever the child slumbers, and further if the mental condition—the settled characteristic melancholy is apparent, we need not wait for further development to diagnose the disease.

Another symptom connected with teething is often present in children in whom the disease has started, after one or more teeth have irrupted. It is the prolonged interval that elapses between the cutting of single teeth or pairs of them. These intervals are, as a rule, reasonably regular in healthy children, and any unusual delay in the continuance of the tooth evolution should not be allowed to pass unnoticed.

When these conditions are recognized it is neither an act of prudence or wisdom to delay a radical change of diet. The child should be taken from the breast at once, and placed on artificial food. At the same time it should be given, systematically and persistently, the indicated homeopathic remedy. Our pharmacopœia is rich in remedies of untold value in these cases. *Mercurius solubilis*, *colchicum*, *asafoetida*, *silicea*, and *sulphur* have all been given successfully in appropriate cases, besides many more which I need not name. But the remedy of all remedies—the one which is in the truest sense homeopathic to the typical case of rachitis in all its stages and phases—the one remedy to be first thought of in the incipency of the disease—the remedy which, in itself, is a standing monument to the

genius of him who gave to the world the immortal aphorism, "*Similia, similibus curantur*," is phosphorus. Whoever reads a proving of phosphorus, reads a description of the essential features of rachitis. Even in the cases of poisoning from this drug, there is much that is suggestive of its disease *similimum*. Phosphorus has produced osteomalacia in the adult, a diseased condition, which, in its course and nature, is almost identical with the rachitis of infancy. But clinical experience shows that we do not get the best value of phosphorus when we give it in its simple and direct form. It combines too readily with oxygen to form phosphoric acid for it to serve our use. By adding it to lime, however, and forming our *calcareo phosphorica*, we have a remedy for rachitis *par excellence*. Calc. phos. covers more completely than any other single remedy the full picture of a typical case of this disease. It has both fontanelles open; tardy dentition; sweating of the head; the pot-bellied abdomen; indisposition to being handled; the settled melancholy; the soft spongy condition of the bones; and indeed the whole catalogue of symptoms with which you are so familiar. Many of these symptoms are also covered by *calcareo carbonica*, but not to the same extent and fullness. Comparing the two drugs I should say that calc. carb. meets more quickly the objective symptoms, while calc. phos. more its subjective ones. In other words, the first acts on the blood and the soft tissues, while the other affects the osseous and the harder tissue. The one acts superficially; the other more profoundly.

But medicine alone will not cure rachitis. The treatment must be hygienic and dietetic as well as medicinal. As we have seen already, the original ætiological factor always present in the disease is defective food. This defect must be corrected; the food must be changed. Cow's milk as an exclusive diet is in these cases inadmissible. Its tendency to form lactic acid simply feeds the morbid condition. All foods requiring an addition of sugar to make

them palatable are injurious for the same reason. If you take an atom of sugar and split it in two you get as a result an atom of lactic acid and an atom of alcohol. But lactic acid is already in excess in the blood, and is creating mischief in all the tissues. To add more is to add fuel to the flame. For this reason all starchy foods are pernicious; and this is why the great majority of the so called "baby foods" fail to meet the requirements of these cases.

Undoubtedly the nearest approach to an ideal substitute for human milk, and certainly the one best adapted to the needs of a rachitic child, is the dextrinized food of Liebig. In the preparation of this food all of the starch of its constituents—wheat and malted barley—is transformed into dextrine and grape sugar. It therefore requires no additional sweetening. Being prepared from the entire grain, it is rich in phosphates and other earthy salts, and all needed nitrogenous matters.

There are various preparations of malted foods in the market, but I am free to say that I prefer that known as Mellin's Food to any other. Perhaps my preference for it is due to the fact that I am more familiar with it. Certain it is that in the nearly twenty years that I have used Mellin's Food I have never seen a child become rachitic under it, while I have seen numerous cases that had become rickety under other foods restored to sound health by its use. It is more highly dextrinized than any other of the malted foods, and is more uniform in its preparation. When mixed with cow's milk in due proportion it fulfills every requirement for the full nutrition of a healthy child.

The brief time allotted to me precludes a scientific comparison of different foods, or even a mention of them. I have made no attempt to exhaust the subject which is here presented, either in the matter of food or other aspects, but only to draw attention to certain points that to my mind

needed emphasis, and to record my personal experience and individual observation in the matter of therapeutic and dietetic treatment.

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## THE AWKWARD GAIT OF CHILDREN.

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BY

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I DESIRE to call attention to a class of cases which, as a rule, are much neglected. These cases are the children who walk awkwardly, with toes turned in and knees knocking together, but not to a degree sufficient to induce the parents to seek surgical advice.

This awkward, shuffling gait is generally attributed to laziness or carelessness on the part of the child, who may be constantly lectured on the subject and told to turn out his toes, which he may do for a short time in a constrained manner, with hands spread out as though he were trying to walk and balance himself on the edge of a board. Frequently, under the watchful eye of the parent or nurse, the child may with difficulty maintain a correct position, but the moment his attention is diverted the bad position is resumed, or, if very much wearied by a long walk or other exercise, the deformity (for such it becomes then) will be greatly exaggerated.

The toeing in is not the only form of the trouble, but it is frequently, if not generally, combined with a partially flexed knee. Sometimes the toes instead of turning in turn out, and the arch of the foot is depressed.

The general belief is that the child will outgrow the trouble, and to a great extent as he grows older and becomes more self-conscious he does manage to conceal it,

but neither the cause nor the difficulty itself becomes entirely removed. As the child grows older he becomes ashamed of his crooked legs and awkward gait, and makes an effort to correct them, but he does it at the expense of unusual fatigue and a strain upon weakened muscles.

The cause of the difficulty under consideration is that there is an unequal balance of muscular power on the opposite sides of the limbs. Either through some prenatal influence or some condition developing subsequent to birth, the muscles of one or more groups become partially enervated; in other words, partially paralyzed. This term is perhaps too strong to apply to this condition; probably the term weakened muscles is better. At any rate, whichever term is applied, the fact remains that the weakened muscles fail to do their whole duty, and the consequence is the bad positions and the awkward gait before mentioned. Under the stimulus of the will the position may be corrected and remain so as long as this stimulus is acting, or until over fatigued, when the muscles give up in despair and become more relaxed than ever. I have seen a child who had a moderate degree of toeing in under ordinary conditions become absolutely deformed on returning weary from a picnic, and the feet so badly turned in that in walking he raised one foot over the other to avoid hitting them together.

The study of the reflexes and causes of nervous and muscular strains are now being actively pursued by the profession, and why not pay some attention to the condition here presented. The nervous irritation induced by unequal muscular balance of the ocular muscles and the reflex irritation of spasmodic contraction of sphincter muscles will doubtless be considered at this meeting; but we must remember that the human system is a confederation of parts, and a weakness in one part weakens the whole, and that anything which acts as a drag or which causes an unhealthy weariness during the formative period of life must leave a more or less lasting effect if allowed to remain un-

corrected. I do not wish to exaggerate the importance of the subject; the children thus afflicted may not give evidence of any special reflex irritation. As a rule, if a child does not suffer actual pain he does not complain, the only indication perhaps is the awkward hobbledehoy gait and weariness.

The muscles usually most affected are the perinei in the leg and the quadriceps extensor in the thigh. The other muscles may be affected, but weakness of these in particular is most likely to cause the condition of toeing-in and flexed knee. If combined with laxity of the internal lateral ligaments of the knee joint we also have the condition of "in-knee" or "knock-knee."

As the whole trouble consists in the lack of muscular balance, the indications for treatment are plain. The strength of the affected muscles should be brought up to the normal after a careful comparative test of the strength of the opposing groups. This should be done by one skilled in finding the motor points on the surface of the limb, with the galvanic current.

The comparative tests should be made of the excitability of the opposing sets of muscles, and the results as shown by the milliampèremeter carefully noted, due allowance being made of course for the varying resistance on account of the varying distances of the nerves from the surface, etc. Then the treatment of the affected muscles by galvanism should be carried on systematically, the applications being made from two to six times a week as the case may require. In addition to this, massage to the affected muscles should be given regularly, and if any constitutional condition seems to indicate their use internal remedies should be employed.

In some cases mechanical treatment may be necessary as an adjunct to the electricity and massage. For this purpose a light bar fastened to the shoe and running up the outside of the leg to a pelvic band should be employed. There should be joints in the bar corresponding to the



ankle, knee, and hip joints, and the amount of eversion of the foot may be regulated by a set screw between the knee and hip. This brace may be made very light and only strong enough to produce the effect desired.

It is necessary to have the pelvic band with the brace extending from it to the shoe, as it is impossible otherwise to get sufficient leverage to evert the foot.

In very severe cases it may even be necessary to employ a more powerful apparatus like Doyle's spring rotator, but cases of such severity hardly come within the range of this paper.

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### THE TREATMENT OF MENINGOCELE, ENCEPHALOCELE, AND HYDRENCEPHALOCELE BY MEANS OF A COLLODION CAP.

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BY

J. MARTINE KERSHAW, M. D.,

ST. LOUIS, MO.

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**I**T has been my misfortune to meet with several cases of meningocele, encephalocele, and hydrencephalocele. Most of them died in the course of a few weeks or months; convulsions preceding death. Of the three forms of tumor hydrencephalocele may be considered the most unfavorable. These tumors consist of brain substance, the meninges, and fluid. Encephalocele consists of cerebral substance only, while a meningocele contains the membranes of the brain. These protrusions have been taken for polypi, abscesses, vascular growths, and cephalæmatoma. These tumors have been treated by injection of iodine. Mr. Annandale ligatured the mass in one instance and effected a cure. Bandages have been employed, muslin caps lined with cotton, and guttapercha caps filled with wadding; all of these get out of place easily; they have to be re-applied

frequently, and besides, they do not afford the child's head any protection. From the moment these protrusions appear they are constantly in the way, and as constantly being bruised or injured in some way. If the child is lifted up, or laid down, the diseased part is almost certain to receive injury, and thus retard any disposition toward recovery.

After some very disappointing experience I adopted the following treatment: Immediately upon the discovery of a case of cerebral protrusion I paint the protruding part with collodion. I order the nurse to do this three times a day. The collodion is carried entirely over the tumor, and down upon the scalp one-half an inch below the lower line of the protrusion. In twenty-four hours the hardened collodion has made a light, strong, cartilaginous-like cap, which fits loosely yet perfectly the protruding cerebral substance. From the moment it is applied the child is protected from all ordinary chances of head injury. Its head can be washed, its hair brushed, and it can be laid upon its pillow with but little chance of injuring the diseased parts. If the tumor protrudes much, it raises the plate, and yet is still covered by it. At the expiration of a week or so, I only paint the upper half of the plate and scalp, leaving the lower half free to permit of spraying or syringing with carbolyzed water. This is done three times a day. I have prescribed belladonna and calcarea phosphorica as indicated. I have just dismissed a case of this kind, the treatment of which was very satisfactory. The opening closed gradually, new matter being deposited, until at this date not a trace of the disease can be seen, and the child is, to all appearances, mentally and physically well.

Dr. S. B. Parsons saw this case with me and at his suggestion I prescribed calcarea phosphorica, and this I believe hastened the cure. I present this paper for your consideration, because the management of this class of cases is usually difficult and very unsatisfactory; while the

formation of a protective cap with collodion is original with me, as far as I am able to learn in looking over the literature of this subject.

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## INVERSION OF THE UTERUS.

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BY

KATHERINE G. TOWNSEND, M. D.,  
NEW YORK.

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THE recent publication, in one of the leading medical journals, of the clinical history of an adherent placenta and inversion of the uterus, tempts me to place upon record a somewhat similar case.

Upon February 13, at 7 P. M., I was summoned to attend a Mrs. S., residing upon Eighth Avenue, near 125th Street. When I reached the lady I found her in labor, and an examination revealed a normal presentation with the os dilated to the size of a silver dollar.

About nine o'clock the membranes ruptured, but the child was not born before 3 A. M., the pains in the meantime almost ceasing, and very infrequent, not becoming strong until about fifteen minutes before the birth.

After the passage of the head under the symphysis considerable force was necessary to extract the body, and the perineum was ruptured, even though well supported and anointed with hot oil. The child was a well-developed girl weighing, I should judge, about ten pounds. Some artificial stimulation was found necessary before perfect respiration was established and good strong cries elicited from the infant. By this time I was ready to make traction upon the placenta, and I supposed that, like almost every other placenta, it would come away easily and well.

I could not, however, by any well-known method, possi-

bly extract it, and I was sure, from the strong pulsation in the cord, that it was tightly adherent. Fearing at that time to use force, I studied the case and prescribed pulsatilla, which I considered indicated, not only from the want of expulsive powers of the uterus—which was so irregularly contracted—but from the peculiar mild and weeping disposition of the patient. She had wept almost incessantly since my arrival.

I administered this remedy low, and waited four hours. There was some pain, and a continual though slight flow.

Temperature was now 102° F. and pulse 100. Patient was very restless and complained of a bearing down sensation and that the parts had a loose feeling as if they would drop apart. I changed the remedy to *secale*, watching and waiting until midday. She was exceedingly restless and uneasy, and wild for sleep.

By midday I had determined to remove that placenta by force, having been totally unable up to this time to bring about the proper uterine contractions, either by friction over the uterus or pressure upon the organ, or by remedies. Carefully observing the proper antiseptic precautions by bathing the vagina, external genitals, and my hands in a bichloride solution 1-1000, I, with the aid of my attendant, partly anæsthetized my patient, having first emptied the bladder and the rectum, and stimulated her. I experienced no difficulty in introducing my hand and in finding one place between the placenta and the uterus where I could insinuate my fingers. By gradually working about I separated the placenta, managing to close my fingers upon it and scoop it out very slowly. I repeat that I did this very slowly and carefully, wishing to avoid unnecessary suction. Notwithstanding, however, my care, I was horrified to find, at the entrance of the vulva, and following my hand, a soft, boggy, globular bleeding mass. I saw at a glance that the uterus was inverted; brought down, I suppose, by suction. Throwing aside the placenta and forming

my fingers into a cone, I pushed upward and forward upon the inverted fundus, entirely replacing it, then, having at hand hot water, previously well boiled, I thoroughly irrigated the uterus and packed the vagina full with sterilized cotton, with which I had supplied myself in case of an emergency. External pressure was kept up and the patient well stimulated. She rallied well, and after being sponged with hot alcohol, she fell into slumber. I persevered with the *secale cornutum*, giving it this time in the 3d potency. The last had been the 30th.

My patient slept almost three hours, at the end of which time I again plugged the vagina, pushing the cotton well up and about the cervix. The hemorrhage had almost ceased, and the uterus was contracting well as the patient complained of after pains.

Temperature was now 100°, and pulse 99.

For the tenderness and soreness about the abdomen I changed the remedy to *arnica*, besides packing hot flannels, soaked with alcohol and *arnica*, across the abdomen.

I remained with this woman almost continuously night and day for four days, and until the milk was established, studying the case well in the meantime, and dosing everything in my power according to the latest and best methods. The lochia was of the proper color and consistency from the first, and I had the happiness of not only bringing this lady through a most dangerous labor, but of having fall within my experience a very uncommon case, dangerous as well as formidable.

Upon learning the history of my patient, I found, as a predisposing cause of this accident, that she had had two abortions, and that for a long time before marriage she had been treated for prolapsus; also that during this last pregnancy she had been threatened with miscarriage three times.

As an exciting cause the sudden delivery of the child, after the almost complete cessation of pain for a number of hours, together with the relaxed condition of the muscular

walls, might and would account very probably for the condition of affairs.

During the entire puerperium I kept this woman in a reclining position, and since her recovery have treated her successfully for prolapsus.

If anyone has had a similar experience, it would give me pleasure to read it. Any suggestions also, or criticisms upon this case would be valuable to me.

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### CURETTING vs. TOPICAL APPLICATIONS IN ENDOMETRITIS.\*

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BY

H. J. RAVOLD, M. D.,  
ST. JOSEPH, MO.

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I SHALL not attempt to give an exhaustive review of the history, causes, symptoms, and treatment of endometritis in all its forms; nor will I dwell on the slight cases which often occur in virgins, and which are quickly cured by internal medication alone.

It is my purpose to deal briefly with those cases caused by specific poison, or due to miscarriages, abortions, and other agents which come in contact with the endometrium.

Almost all physicians have a number of obstinate cases of leucorrhœa which baffle all ordinary means of cure. The discharge is often of such a corrosive nature as to cause vaginitis and an ulcerated state of the vagina and vulva. Internal medication, no matter how carefully the remedies have been selected, has proved, in my experience, ineffectual in making a cure. I have never secured more than temporary relief for them. Most physicians combine internal and local treatment.

\*Read before the Missouri Institute of Homeopathy, 1893.

The various forms of glyceroles have been the most popular for local use, and in some of the milder cases the results have been very good

Last fall I treated, and have apparently cured, a case of uterine leucorrhœa with kreosotum internally and glyceroles of hydrastis locally. Numerous other cases have received only temporary relief from the treatment, and it was only when the patients would consent to have surgical treatment that I have been able to give them permanent relief. When the disease has been present for years, a pathological condition is present which in many cases is characterized by a great destruction of mucous membrane, and often there is formation of pus. The menstrual function is always irregular. There may be scanty or profuse menstruation. It may last one day or one week. It may appear every four weeks, three weeks, two weeks, or one week. There may be menorrhagia or metrorrhagia. Often there is dysmenorrhea.

Very often we find a cystic condition of the cervix, especially if caustics have been previously used, and the ducts of the nabothian glands occluded. In addition to the endometritis we often find lacerated cervix uteri; irritable and inflamed urethra; the hood of the clitoris adherent to the glans, and concealing an amount of smegma; carunculi about the meatus; hemorrhoidal and other irritations of the rectum.

In order to get the best results from the curetting of the endometrium, these other points of irritation must be removed; and in addition I would thoroughly dilate the sphincters of both rectum and bladder in order to rouse up the sympathetic nervous system, and through its activity get a more perfect functional activity of all the organs of the body, and especially of the capillary circulations.

When the cervix is cystic the cysts should be punctured and their contents evacuated, and the cervix should receive local treatment, in the form of glyceroles, to soften it and

relieve the congestion, for several days before the operation is performed.

The universally recognized aseptic and antiseptic precautions should characterize the several steps in the operation.

The patient must be anæsthetized if you would do thorough work. Cocaine is not sufficient.

The uterus should be grasped with a volsellum forceps or a tenaculum and brought down to the vulva. If there is a lacerated cervix, guy ropes of braided silk should be introduced into the anterior and posterior lips. Graded female sounds should be introduced clear to the fundus of the organ, using increasing sizes until the uterine canal has been dilated to the same size throughout its entire length.

You will sometimes find the cervix so hard, and apparently cartilaginous, that the sounds cannot be introduced without first using a strong uterine dilator, such as Sims' tri-valve, or Goodel's.

You are now to take a sharp uterine curette and thoroughly scrape the endometrium, not omitting the cornua.

The best form of curette is one combining a douche and curette. An excellent one is the Holbrook instrument which is made in Chicago. It should be attached to a fountain syringe which contains a solution of bichloride of mercury 1 to 2000 or 3000.

As you scrape away the granulations and other diseased tissues the *débris* is washed away by the antiseptic solution.

Having removed all the diseased tissue you are to take strips of iodoform gauze or antiseptically prepared candle-wicking, and with uterine forceps pack the uterus. The first dressing should be removed and a second one introduced. This should be left until you have prepared the lacerated cervix for the sutures, if that operation is necessary, and should then be removed.

The patients usually make a prompt recovery. One important point is to thoroughly dilate the uterus so that



there will be free drainage, otherwise septicæmia is almost sure to follow.

A hot-water vaginal injection from a fountain syringe should be used daily for a week. I will report some typical cases :

CASE I. Married woman, æt. forty-eight years, mother of several children. Had one miscarriage. For years she had a corrosive leucorrhœa. It was so irritating that she was obliged to use hot-water injections three or four times every night in order to rest at all. There was also intense irritation and congestion of the urethra, causing painful urination.

The hood was adherent to the clitoris. She had ovarian pains and some rectal trouble. Indigestion and sick headache were almost always present, and she was generally used up. Besides all these troubles she had a hemiplegia, which had been present for a year.

In addition to removing all other points of irritation, I dilated and curetted the uterus and packed with iodoform gauze.

It has been nearly four months since the operation, and there has not yet been any leucorrhœa. The sick headaches, irritable urethra, and other troubles have been relieved, and, with the exception of the hemiplegia, which is about the same, she feels like a new woman.

CASE II. Married woman, æt. thirty-four years. Has three children. Has had leucorrhœa and dysmenorrhea for several years ; also backache, headache, and is generally depleted.

An examination revealed lacerated cervix, adhesion of hood to clitoris, and some urethral irritation. Menstrual periods last only one day, and come at irregular intervals.

Operation was performed February 17. After removing the other points of irritation, the uterus was dilated, curetted, and packed with iodoform gauze. The citatrical plugs at the angles of the cervical laceration were removed and the edges freshened and prepared for coaptation. The

gauze was then removed and the lips united by six silver wire sutures.

In one week the sutures were removed and the union found to be perfect. At the next period the flow lasted four days and was normal. At the second period the flow continued four days, and there has been no return of the obstinate leucorrhœa.

CASE III. In another case operated on last month there has been great improvement, but the time has been so short that it is not of much clinical value.

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### DYSMENORRHEA.

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BY

J. H. SHERMAN, M. D.,  
BOSTON, MASS.

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THIS term has been and is applied to any and all kinds of suffering connected with menstruation, whether caused by diseased conditions of the uterus, ovaries, or fallopian tubes; or, as is often the case, the cause lies in a disordered condition of the nervous system or defect in the general health.

If we could know beyond a doubt just what is the physiological process of normal menstruation, we could the better diagnosticate and treat those pathological conditions with which we meet and which are prolific of so much mental and physical suffering. But while the normal function is still a matter of speculation to some extent, the cause of diseased conditions must be somewhat clouded by uncertainty. We cannot help thinking that any natural function ought to be performed without appreciable suffering; but so far as my observation goes, the number of cases where this process is accomplished without pain are very few com-

pared with the great number in which suffering is the rule—and often very intense suffering, which disables the person from one to five days. Indeed I am sure that many women endure more pain at each monthly sickness than many others at confinement.

Many of these cases are among unmarried girls and women who have borne no children; but I cannot say, speaking from my own observation, that dysmenorrhea is more common in one class than another, for I have seen some of the worst cases among the rich, who have nothing to do but seek their own pleasure, and the poor who are employed in shops and stores, and who are overworked in various ways. Neither do I think that intellectual pursuits have any marked effect in these cases, except that any exhaustive employment may affect a weak and debilitated organ by its depressing action on the nervous system. I am frank to say that I have no sympathy with the notion that girls cannot endure a good, fair amount of intellectual work, and be the better for it. If they can endure fashionable dress and society life, surely a little (or a good, fair share) of healthful scientific study cannot harm them; and it would be well to remember, in studying these cases, that women have other organs besides uterus and ovaries.

Some of our leading gynecologists object to the term neuralgic dysmenorrhea (or to making any classification whatever), and hold that all such troubles are due to hyperæmia of the endometrium, local congestion, or malposition of the uterus.

I am very certain, however, that not a few cases I have seen of the severest type were due entirely to a disordered state of the nervous system.

One case occurs to me now of a young lady about twenty years of age, who had the pleasantest surroundings that wealth and kind friends could furnish, who suffered very severely at each menstrual period. She was not oppressed with intellectual work of any kind, and she had plenty of

out-of-door exercise, being a great walker, and she had pleasant and agreeable companionship. I was often called to relieve the distress (caused by the appearance of the menses) which usually lasted for twelve hours or more; and always for several hours after the flow had been established.

This led me to suspect some unhealthy condition of the os or cervix, such as atrophy, hardening, or want of development; but physical examination revealed nothing amiss in that direction, and a purely accidental circumstance brought to light a new factor in the case, viz., an excessive use of tea.

I found the young lady in question to be in the habit of drinking from eight to ten cups of tea in an afternoon, and she even confessed to having taken nineteen cups in one day.

She was thin and sallow, with no appetite and a constant craving for excitement.

At my earnest request she left off the tea altogether and has drank none since that time, which was several months ago. In less than a month the general health began to improve, she gained in flesh and color and appetite, and the dysmenorrhea has gradually gone, so that she is no longer an invalid one week out of four.

This is an unusual case, but there are others quite as interesting as illustrative of the fact that a badly nourished or over-stimulated nervous system is often at the root of this evil.

I find a good many cases where an excessive use of coffee increases the flow to such an extent that the whole system is exhausted by it and neuralgic dysmenorrhea is the result. In nearly all cases where the defect is from want of vitality or badly nourished nerves, the flow is excessive and debilitating.

It is still a matter of discussion whether we can properly say that there is such a condition as ovarian dysmenorrhea.

Some writers claim there is not, and that the apparent ovarian pain at that time is due to the fact that the diseased uterus is disturbed in consequence of ovaritis or salpingitis. The term is a very common one, however, and very well describes dysmenorrhea where the pain is located in the ovarian region. Whether this pain is due to ovaritis, or sympathy between these organs, or from continuity of mucous surface, we are sometimes unable to discover, but from the fact that it in some cases alternates from side to side each month, or is absent altogether one month and persists on one side the alternate month, we naturally conclude that the ovaries or tubes are involved. What concerns us most is the best and most speedy method of cure.

Membranous dysmenorrhea is more discouraging than any of the other forms, and often baffles the most skillful attempt at cure, although some brilliant results are reported from the use of internal remedies.

Fortunately for the practitioner and the victims this variety is more seldom met with than the others, since the suffering is very intense and continues during the whole period, or until the membrane has been expelled, either in shreds or as a cast of the uterine cavity, and relief is uncertain.

In speaking of obstructive dysmenorrhea we usually intend to signify that there is some mechanical obstacle which prevents the escape of the menstrual fluid, but Dr. Barnes goes so far as to say that he thinks a large majority of cases of dysmenorrhea under all these various classifications are obstructive in their nature either primarily or secondarily, *i. e.*, that they are due to retention of the flow either in the uterine tissues themselves from continued congestion, from occlusion of the os internum or externum, or from flexion.

*Treatment.*—Before undertaking to treat a case of dysmenorrhea I always like to discover, if possible, the pathological condition which causes the manifestation of pain at

that time. This is not always expedient as many patients, especially the younger ones, object to an examination, and I am compelled to administer remedies at first without being able to make a clear diagnosis.

I do this with the proviso that, if relief is not felt within a short time, I shall insist on a thorough investigation. If the examination becomes necessary, and I find the cause of trouble to be obstructive from malposition, occlusion, or want of development, of course mechanical means must be resorted to, such as dilatation, re-position, etc.; and in cases of non-development electricity is often most beneficial. If congestive, a systematic course of local treatment, combined with internal remedies, will usually effect a cure in a few months. The suppositories of glyco-boron, followed by the hot-water douche, in these cases are quite invaluable. The sitz bath is a great help if judiciously used. If the patient has sufficient vitality to bear it, a cool sitz bath once a day during the month will do much to give tone and strength to the reproductive organs and thus assist in warding off disease. This may be followed by the hot sitz bath for two or three nights before the expected sickness.

In endometritis a careful use of intra-uterine suppositories or applications is beneficial, but these ought to be used with great caution, lest the proposed remedy be harder to bear than the existing disease. I cannot say, as some practitioners do, that remedies are of no avail in dysmenorrhea and that nothing except anodynes is even palliative.

On the contrary I have seen, and do continually see, the best results from the use of well-selected remedies, both at the time of menstruation and in the interval between.

I have not spoken here of one prolific source of this and other kinds of uterine troubles, viz., improper methods of dress and living. If I find a patient suffering from prolapsus, retroversion, or antelexion and find also a tight corset with all the weight of heavy skirts and underclothing resting on the abdominal muscles and dragging down on the back, I have no more hope of curing the trouble with

its train of evil effects, without instituting a new system of dress, than I should have of pulling a delicate child out from under a weight of forty tons without first lifting the weight: and there is no question that many cases of dysmenorrhea have had their origin in these evil methods of dress, and have gone on from year to year until structural changes have taken place in the uterine tissues due to imperfect nutrition, and by obstructed circulation and its result we have congestive, obstructive, or membranous dysmenorrhea.

If, however, the case is taken in hand before such changes have taken place, and the patient is willing to adopt a sensible method of dress and take proper exercise and institute healthful ways of living, a few weeks' treatment is usually sufficient to effect a cure.

I cannot fairly bring this paper to a close without speaking of laparotomy as a means of cure for severe cases of dysmenorrhea. I have never recommended it, although I have had the opportunity to observe several cases in the hands of other practitioners—some surgeons having performed the operation frequently with a real desire to relieve the sufferer, and others from a desire to experiment and keep in fashion. I cannot say that I have seen any very brilliant results. Some patients continue to menstruate after the operation, especially if only one ovary has been removed; and the worst case of hysterical convulsions which I have ever had under my care occurred in a young lady whose ovaries had both been removed for the cure of dysmenorrhea. The convulsions came on quite regularly every month at about the time for menstruation, and lasted from twenty-four to forty-eight hours with no relief except from anæsthetics.

Another young woman who had one ovary removed, menstruated with perfect regularity, with more or less pain, and great nervousness.

These, and similar cases, have stood in the way of my enthusiasm over this method of cure, but I am aware that other physicians and many specialists have observed as carefully and have seen better results. At all events I have nothing to say against any practice which will relieve suffering.

The remedies which have served me faithfully are: Verat. alb., pulsatilla, bell., viburnum, gelsemium, cimicifuga, kali phos.

## ● EDITOR'S TABLE. ●

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AT the recent medical congress in Chicago Dr. John Williams Streeter read a very valuable paper on uterine fibroids, which occasioned an interesting and prolonged discussion. Dr. Henry W. Roby said : "Medicines as a rule prove inefficient and practically worthless so far as the removal of these neoplasms is concerned. At best they can only serve the purpose of palliating some of the collateral symptoms in the case. We see in the medical journals occasionally, it is true, reports of some of these cases being cured by the use of remedies, but actual cures are very few. Since Lungren promulgated the plan of cutting off the nutrition of these growths, cutting off the blood supplies from the uterus, a good deal has been done in the way of progress in the management of these cases. Dr. Boothby has achieved a great deal of reputation in the treatment of these cases by simply cutting off the blood supply, removing in many cases the entire ovaries and tubes, and ligating the uterine arteries. I have found success attending a number of cases, and where I have tried it I have had no failures in what I might call the Pratt treatment, which consists simply in treating the rectum and the uterine cavity by the methods taught by Professor Pratt. Where there are disorders of nutrition, where there are hemorrhoidal conditions, where there are conditions of false growth, false membrane, and spongy conditions of the endometrium, a disordered condition of the blood supply of the uterine structure, I have found that by dilating the rectum and clearing up the hemorrhoids, and setting the circulation going in a normal condition, these growths, especially the intra-mural growths, have in the course of two or three months disappeared, or have very much diminished. I have in my mind one case where I was telegraphed to go one hundred miles to see a patient who was bleeding to death from internal tumor. When I arrived the patient was exhausted and scarcely able to lift a finger or to speak above a whisper. I found there was a growth of a very large size pro-



truding, and immediately removed it. She made a good recovery, but in a little while another developed. She then came to Chicago, and a very prominent surgeon in this city removed the growth. She went home to Kansas and in a short time another developed. She came back to Chicago, and for some reason or other, I know not what, the surgeon to whom she had applied at first here, who had removed one tumor for her, declined to operate again and sent her home. She came to me again and I anesthetized her and made preparations for removal, but after I had given her an anæsthetic and dilated the rectum sufficiently, so that I could pass my hand and make a more thorough exploration, I saw the tumor was intra-mural, involving at least one-half of the uterine wall, and I thought I knew enough to back out of the undertaking. I did back out. When she recovered from the anæsthetic I said to her that I believed the Apostoli treatment was the right one for the case. I gave her galvanic treatments for three months, every day for three weeks of this time, and then, when the period passed, the hemorrhage being comparatively insignificant, I applied it every other day for another three weeks. When the next period recurred the hemorrhage was almost entirely abated, and after that I gave another month's treatment. The patient went to California and I had a letter from her a few weeks ago, saying that, so far as she could discover, the tumor had entirely disappeared. In that case, as nearly as I could ascertain, the tumor was as large as a moderate-sized cocoanut ; but by giving the galvanic treatment it has entirely disappeared.

"I remember a case that occurred in my city, where the patient had a very large growth of that kind. She had the treatment of a number of physicians and finally she wanted to go back to Scotland, of which country she was a native, before dying, and I gave her a letter of introduction to Mr. Keith, who was at that time, perhaps second to Apostoli, the greatest apostle of the galvanic treatment. He gave her the treatment three months and told her he could do nothing for her. He had arrested apparently the growth, and caused a diminution of probably one-half the size of the growth. It was intra-mural. She came back to me, and I took up the treatment again myself and followed it for about three months longer, in which time the tumor almost entirely disap-

peared and she is now in good health, vigorous and active, doing her own work about the house, and seems to have very little inconvenience whatever from it.

"In the great American desert we raise a good many things. We raise Cain-sometimes, we raise wheat and corn, and we raise some large tumors. You remember a few years ago perhaps that Mr. Nast, in making an illustration of the Kansas calamity of grasshoppers, pictured a field of wheat and a rail fence, and on the other side a very large grasshopper, and with it the motto, 'In this wheat by and by.' Now in that country, where we raised two hundred millions of corn and a hundred and fifty millions of wheat in a year, we sometimes raise large tumors. I have bottled up in my office, and I meant to have brought some photographs of it, but forgot it, a fibroid that weighs thirty-six pounds avoirdupois. It was subperitoneal. It required the making of a large abdominal section, a long incision, and the tumor, when severed from its attachment, filled a good foot-pan almost level full. I took it to the undertaker to see what he could do in the way of preserving it, and he embalmed it for me. He passed his trocar and his aspirator in the tumor at least in fifty directions, and could find no sac or cavity or any liquid of any kind; the growth being entirely an absolute solid through and through. I am very sorry I cannot produce it, because it is really a rare sight. It was a bloody piece of business, but I was fortunate in getting it out safely."

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THE discussion was continued by Dr. George Royal, who said :  
"Eight years ago there came under my care a lady, who had been married five years, suffering from all the symptoms of a fibroid. She went to New York and was examined by Thomas. A diagnosis was made of an interstitial fibroid, and she was put upon the treatment of ergot by hypodermic injection. The result was not satisfactory. The tumor increased and she went back for a re-examination, taking a sister with her who was suffering from the same condition, and who was to be operated upon also. The sister died in the operation. The woman returned home, having firmly made up her mind that she would live as long as

she could, and refusing to have the operation performed. I did all I could to encourage her and to have her submit to an operation, but she objected. Then I thought there was just one thing to do, and that was to ameliorate the symptoms as much as possible. She was obliged to be in bed about eighteen of the twenty-eight days. I put her upon trillium, to control the hemorrhage. The result was slow, but I could see improvement. More than that, after about one year's treatment—and she took this trillium fourteen out of the twenty-eight days—I could notice a perceptible difference in the tumor, and she became pregnant. She miscarried during the five years under treatment three times, but after being treated about five years and two months, and I should say taking trillium about two-fifths of that time, she gave birth to a child at term, and at that time I should think the tumor, which before had been larger than a good-sized orange, was hardly perceptible. The child is now about three years old. The woman I have examined twice and am now unable to find any traces whatever of the tumor, and the woman is in perfect health."

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CONTINUING the discussion Dr. Everett B. Finney said: "I had a case come to me this fall. My patient wanted a child if she could possibly have it. She said: 'Doctor, I have faith in homeopathy, and if you can save my ovaries do it above all things. Make an operation the last resort.' I found the operation a tedious job. I made a long incision through the mucous membrane to the tumor, and then grabbed it with a pair of forceps, ordered especially from Philadelphia, and with a long pair of shears I removed it piece by piece. It, whole, weighed three pounds and a half. I believe that we as homeopathic surgeons, especially scattered through the West, are afraid of criticism that may reflect upon our school if a case results disastrously, and again, I have a horror of removing an ovary, if there is any way of preventing it, and I believe if we will only use care, and take these cases and instruct our patients that an easy operation will prevent failure, and maybe give conception, I think that is our duty as surgeons."

DR. BIGGAR then spoke as follows : " In the use of electricity I have found this, that it is of no use in these tumors at all. In fibro-cystic, or soft tumor, you get a condition of septicæmia which you must avoid. The advantage of electricity is in the smooth round tumor. One other point which is a clinical experience with myself, that there are two remedies very valuable. One is ergot, and the other is ustilago. But there are two conditions in which one is good and the other bad, and *vice versa*. If you have the hard fibroma you get good action from ergot, but if it is soft you get good action from the ustilago. One word more : in whatever condition you may find a uterine fibroma in all the varied varieties, do not hesitate to look well to the diet, because it is true that this neoplasm is caused from connective tissue, and connective tissue is fed by starch or sugar. Put your patient on the roast beef, or red meat diet, and exclude all starches, and give them nothing but good green vegetables, and you will find a great relief from these growths."

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THE discussion was closed by Dr. Catherine Wilcox, who said : " I indorse the statement that galvanism is useful in fibroid tumors. I have had many cases of fibroid, and I am sure that galvanism has served me well. All growths are relieved by galvanism. Six years ago I reported a case of fibroid tumor at Saratoga, which I had revealed, which measured forty-six inches, and which was, in a few months, reduced to twenty-six inches. I heard from the patient not a year ago, and there has been no additional growth ; she has remained well. I am sure it was galvanism that removed the growth and cured her, and I believe that the day has come when galvanism and electricity will be a boon for women in many of their diseases."

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DR. JOHN MALLORY LEE followed with an address upon vaginal hysterectomy, which was ably discussed. The first one to speak was Professor Reuben Ludlam, who said :

" I am very glad whenever I can offer a word, to those who are willing to hear it, that may add to the experience of those who are practicing in so serious a department of gynecological work as that to which this paper has been devoted. Vaginal hysterectomy

is one of the greatest expedients that has ever been developed by modern times. Its resources are almost limitless, so far as it can be applied to the removal of the uterus and diseased conditions connected therewith. Nothing more marvelous, more wonderful, or satisfactory has been done in any department of surgery than this particular operation. I have made it a good many times, and every time have been more and more satisfied of its efficacy and of its wide range of application. This paper does not go into detail with reference to anything except vaginal hysterectomy for cancer, and the technique that is given and the remarks that are made I most heartily approve of. Especially, it seems to me, is it possible to emphasize what the essayist has so well put forth as to the importance of an early diagnosis and to the importance of an early operation, when it is necessary at all. This should be emphasized in the presence of general practitioners ; because such cases are put off until the evil day has come, and the disease has progressed so far that even this resource will be of little avail. The doctor's idea, that curetting had better be left out as part of the operation, is, I believe, perfectly right. As to the desirability of operating upon these patients early when an operation is determined upon, and not to allow them to worry or reflect about it for days and weeks beforehand, and not to bring them to a hospital until you are about ready to go to work, I think an excellent one.

"It avoids a mental shock beforehand, and it puts the patient in the best condition for operation, for she doesn't stop to think much about it. As for the necessity of preparing them for five or six days, I believe that is the correct view. I want to call your attention to one fact, however, and that is that the French are far ahead of the Germans in this matter, and that the best results have been derived by them, for this is a French operation. The technique which the doctor has given you is essentially Paen's operation, or Richelieu's operation, neither of whom is mentioned in his paper.

"As to the results derived from this operation for vaginal hysterectomy Paen has had the best in the world, not even excepting my good friend Dr. Lee, whose records are the best on this side of the water. Dr. Paen's last report gives 158 cases of vaginal hysterectomy, with 158 recoveries. I am something of a French-

man by adoption, and do not want the French left out. I do not believe, where you can help it, in leaving ligatures about the broad ligaments.

"It has been my good fortune to see the operation made in a number of different ways, and by the best operator in the world, Leopold of Dresden, who always uses the ligature, and by others. The Germans will not make the operation by the French method—because it is French; except a single man in Berlin, and he used the clamp or forceps. In Paris nobody will use the ligature—because it is the German method; and the best way for us, who are cosmopolitan, is to have both and use whatever we like, but I believe with Dr. Lee that the clamp is much better and safer.

"I want to say this one thing in favor of vaginal hysterectomy that has been devised or practiced by anybody anywhere. In the excellent paper that we have had on uterine fibroid, nothing was said about these tumors being always multiple, and of their recurrence. They don't come back in the same stump, but there will be another sprout, like potatoes. Now, so long as any of the uterine muscular tissue is left behind by any operation for uterine fibroids there is a possibility and probability of recurrence. If you know your business, you can take them out through the vagina. I have taken out the uterus, with twenty-three fibroids attached to it, by the vagina."

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It is a pity that this discussion, so ably opened by Professor Ludlam, could not have gone on. There were several gentlemen present from whom the congress desired to hear on this important subject, but the chairman cut off debate by calling at once for Dr. Ostrom's paper on the removal of the uterus. To be sure this was, in a sense, a continuation of the subject; but the value of medical congresses lie almost wholly in the debates which follow the reading of papers. Without debate the meeting is lifeless. The paper was read by Dr. T. Franklin Smith, and Dr. Alonzo Boothby discussed it. He said:

"In discussing an operation like 'total extirpation of the uterus through the abdomen,' it is necessary to consider not only the danger attending it and the results that may be expected from it, but we must take into consideration the character of the disease,

whether it is likely to produce serious disturbance or death in the near future, or is likely to remain comparatively harmless for some time. I think we may safely agree with the paper just read that this operation has come to be recognized as not only a justifiable one under extreme conditions, but one that should be frequently made. Probably, in fact I should say undoubtedly, the danger from it is a little more than from ovariectomy, or from the removal of ovaries and tubes, and certainly it is a more difficult one to make under ordinary circumstances, but it is not more dangerous than ovariectomy was a few years ago. The question arises, When or for what diseases shall this operation be done? I should say that, with very few exceptions, it should be done for only two conditions: uterine fibromata and malignant disease of the uterus.

"In the paper I am to discuss the claim is made that the uterus should be removed when the ovaries and tubes are removed, whether it is diseased or not. I should most decidedly take exception to this. I do not believe that it should be removed unless it is the seat of a disease that is not readily cured. The failure to obtain favorable results will not be found to be in a healthy uterus. That must be sought elsewhere. It will frequently be found in a non-absorbable ligature. I assume this because I have had very much less trouble following my abdominal operations since using nothing but catgut ligatures. Another source of trouble is the disturbance to the bowels from their unfavorable position, and from the adhesions which are unavoidable.

"The method of operating has not been quite so clearly put as it might be. True, one long incision and raised hips are essential steps, but when we consider that we are working between the bladder in front and the rectum behind, with the uterus on each side, it becomes necessary to cut and sew with the utmost care. Then it is a fact that, aside from the ovarian and uterine arteries, the parts to be severed are very vascular, and great care must be used to be sure that all vessels are secured. Just here, it may not be out of place to suggest that the case of death, from what the doctor calls secondary hemorrhage caused by the restlessness of the patient, was due to hemorrhage from small, unsecured vessels, and that the restlessness was due to this hemorrhage. I am

very positive in my position that we never have secondary hemorrhage except from a defect in securing the vesicle as the result of a septic inflammation, or from such violence as would be impossible from the movements of a patient.

"After having removed the ovary in the ordinary way I tie the broad ligament in sections and cut it across, keeping close to the uterus. This is done on each side, then an incision is made through the peritoneum in front and back, so as to leave flaps that can be easily united later on. The separation of the uterus from the bladder can be made quite rapidly and safely by keeping hard against the uterus, and the same is true from behind. In case of a perfectly healthy cervix the dissection should be carried well down, so as to leave a comparatively small opening into the vagina. After the removal has been completed then the parts should be brought together, using at first buried sutures, and at the same time closing all the bleeding vessels. This will bring the vaginal mucous membrane well up to the peritoneum, which is to be stitched together, forming a long seam from the site of one ovary to that of the other. In the center a rubber drainage-tube may be carried down to the vagina. This should be held in place by a catgut suture, and should not project outside. If care is used in stopping all bleeding, and in bringing the peritoneal surfaces together, there is scarcely more need of a drainage-tube than there is in making a simple ovariectomy.

"During the past three months I have removed the uterus five times, four of which were for uterine fibroids and one for carcinoma of the uterus, and in neither case have there been any symptoms more severe than from simple ovariectomy; but evidences of a more profound impression upon the system have existed, and it has required a longer time for complete recovery.

"I shall not raise the question as to whether every case of uterine fibroid should be removed, and with it the uterus; but content myself with the opinion that this is the course to pursue in a large number of cases. In carcinoma extending above the vaginal cervix, but not so far as to prevent the removal of all the tissue involved, I should advise total extirpation, and that through the abdomen."



THIS closed the session of the section on gynecology. It had been one of great interest, and would have been of more if the discussions could have been more free. Again it was made apparent, and most forcibly, that more time must be given to open discussion. It is well to have prearranged comment on the papers read. The clash of ideas between the essayist and his appointed reviewer is necessary in order to stimulate impromptu speaking. But it ought to be permitted to so stimulate debate. A rattling discussion not only enlivens a meeting, but is its most valuable characteristic. Those who never talk are at least stimulated to think, and a strong impression is made on the minds of all. It is to be hoped that the powers that be will so arrange the section meetings at Denver that no legitimate discussion shall be killed off by calling time.

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IN the section on obstetrics Dr. E. Stillman Bailey read an address on habitual death of the fetus *in utero* which recalls an experience which befell the writer some years ago. I think it was in 1880 a woman came to my clinic, at the Manhattan Hospital, for some trifling ailment, and engaged me to attend her in confinement, which was expected in about five months. I gave her some routine advice, and suggested that she see me again in about a month. As she arose to go she remarked casually, "The child will be born dead."

To which I made reply, "Why, how do you know that?"

"They always are," she said.

This was certainly a startling assertion, and naturally led to a series of inquiries. But these developed nothing except that she had been twice pregnant; had had during both pregnancies usually good health; the child had been active in both cases up until after labor began, and that in each case it died during parturition, without apparent cause. There was no evidence of syphilitic infection. The woman was thoroughly convinced that in the present case she would have a similar experience. Indeed, so much so that, though I talked to her a number of times in the interval, she would make no preparation for the coming babe. I prescribed mitchella repens, in tincture, five drops in half a goblet of water, taken in divided doses during the day. This she took

for several months, with the result that she was in due time delivered of a well-formed, active, and very much alive boy baby. Of course, in such a case, it is impossible to tell whether the medicine had any effect or not. It certainly did not act on the mother's mind, because she remained to the last stubbornly obsessed with the idea that she could not bear a living child.

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DR. BAILEY'S paper was discussed by Professor Ludlam, who said: "I inquired of the professor whether my colleague mentioned mental shock as a cause for abortion. We all know, I think, that this is one. There are such a long list of causes, he overlooked this, I think. Mental shock does not always induce this result, but that there are cases that might accidentally have this effect there is no doubt. Dr. Bailey's subject is, however, as I understand it, the habitual abortion that occurs over and over again in the same patient. The impossibility of the woman giving birth to a living child—the affliction which she must undergo under those circumstances in not becoming a mother is surely terrible. Surely, if there is anything we can do in such a case, or anything we can suggest as a means of preventing such an experience, we ought to study such a question very carefully. For my part I think there are times in similar cases, not having gone quite so far as these cases—there are times where I induced early labor, premature labor, and the mothers have been blessed with living children. I have sometimes, where this has occurred—several times—done this. Such an expedient is justifiable, especially with our modern aseptic operations. I suggest that we might think of this thing a little oftener than perhaps we have been inclined to do, because it is expedient, and is more justifiable now than it ever was before."

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DR. R. N. FOSTER said: "I would like to offer a suggestion or two with reference to such a case. It would seem that all of the well-known causes of the death of the child *in utero* have been pretty well considered in this case, and were well considered, I think, in the paper read by Dr. Bailey. There is another possible cause, however, to which I would like to call your atten-

tion. Perhaps it might be valuable. Perhaps I might put it in this way, that I would say that the woman would perhaps have a better chance of giving birth to a living child if she had another husband. There have been such instances on record. Where either parent is not fruitful, he or she is likely to be in a subsequent marriage. We see a similar state of facts oftentimes in the vegetable world, where we find a little piece of ground that will always fail to ripen its fruit. It will permit a certain kind of fruit to grow until just before it has reached maturity. Other kinds of fruit it will mature. I am under the impression this case of Dr. Bailey's comes somewhere in that line."

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THE subject of antiseptics was again brought to the fore by Dr. George B. Peck, in his paper with the innocent title, "The Rational Treatment of Certain Puerperal Disorders." In fact the title was so non-committal, and the ideas in the paper so subtly expressed, that we wonder at the storm which it raised. Apparently it was some of that of last year's, which had been bottled up. Beginning the discussion, Dr. Lemuel C. Grosvenor said: "Every evil principle in this world is ready to jump on to us when we are down. If we see a boy going to the bad, we say that is all we expected of him; I knew him when he was a little fellow. There is another principle, it is always ready to boost us when we are going up. Now these two principles are just as active in our physical life as they are in educational life, in our moral life, or anywhere else. When we are in high health, and when we are in diseased condition, these microbes are all around us. They are ready to jump on to us and abuse us. When we are, in a general way, in fine health, they pass by on the other side of the street, and take off their hats to us. This is one of the inducements not only to us as doctors, but to our patients, to always live on a high physical plane."

Dr. Alonzo Boothby said: "When I get a chance on this subject I always take advantage of it. I believe that remedies have a great deal of influence on septic disease, but I should not say that we must depend upon them in all cases; and while the paper has hardly committed the writer to that position, yet that is what it leads to, or what has it led to? Now if we have a perfect

condition of things we do not need any antiseptic, but we do need the aseptic principle put into practice in every single case, and I presume that hardly anybody here would think of attending a case of confinement, any more than they would attempt making a surgical operation, without having everything clean about them. If you have everything clean and a healthy subject to deal with, I say you need nothing more than that ; but suppose you have a diseased vagina, then are you not going to use your antiseptics, and is it not true that a cut surface anywhere will bear these applications with perfect immunity ? I think that those who use them speak most positively in regard to them, and it is not to the advantage of any member of this Association to suppose that they will do harm, because the one who has used them says that they did not do any good in the proper way. Someone spoke of using 1-10,000 of the bichloride solution. Now you might just as well use hot water. This is what you get when you use such an antiseptic. If you use an antiseptic you must use enough of it, and use it long enough to produce some action on microbes, and they would bear that solution for two or three minutes and be just as lively as ever. Besides, we have not to adopt the germ theory. It is possible that it is the poison accompanying the germ, but whether it is the one or the other, the effect is the same."

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THERE followed a little tilt between Dr. R. N. Foster and Dr. Alonzo Boothby, one claiming that a solution of corrosive sublimate, 1-10,000, would have no beneficial effect, in fact would be no more efficacious than hot water, while the other asserted that such a solution had produced serious symptoms, that death had been caused by a 1-5000 solution in more cases than one, and that caution ought to be observed in using even the 1-10,000. Professor Ludlam endeavored to throw oil on the troubled waters ; with what success the reader may judge. He said : "I think it is important to be specific in what we are talking about. My good friend, Dr. Boothby, thinks that such a weak solution of the bichloride as 1-10,000 would be of no great service in the vagina. My good friend, Dr. Foster, speaks inferentially of the bichloride upon the perineum. The bichloride in contact with the perineum is very poisonous in even a very weak solution,

but it is not so in the vagina, unless it chanches to get through into the perineum, so I submit that these two very clever fellows are talking about two different things ; and neither understands what the other is talking about."

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PROFESSOR COGSWELL of the University of Iowa said :  
 " I don't know that I dare tackle this subject. I had occasion to prepare a paper for the American Institute last year, but it is very seldom that I do. I stated in my paper then—I can only reiterate the statement to-day—that I have no use for antiseptics in obstetrical practice. I have never seen a time when it was needed. I know of a great many cases that have been injured by the use of chemicals. I reported twenty cases last year of serious injury from the use of the bichloride, 1-3000, in labor. I try to be clean and keep my patients clean, and when I have done that I believe I have done all that the good Lord asked me to do."

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DR. HENRY W. ROBY said: "One point, I think, it would profit all of us to ponder upon. It seems to me that the homeopathic profession is gradually and surely taking ground against the germ theory of the origin of disease, and we, I believe the majority of us, are coming more and more clearly to the conclusion that it is merely one of the passing fancies of the age—that diseases are not, as a rule, produced by these germs, but they are simply the accompaniments of disease ; they act as scavengers of the system to throw out the morbid product of disease, and that they are blessings in disguise and not our great enemies. We find connected with all the products of decomposition, both in the animal and vegetable kingdom, certain kinds of scavengers which Nature seems to use in her great law of conservation."

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DR. SHELDON LEAVITT said : " I have been slow to put myself on record with regard to this matter of antiseptics, for I have been undecided in my own mind just what course it is best to pursue. I spent some six weeks with Tait in Birmingham, England, and I saw there the utter disregard for these things which

he manifested, and at the same time the excellent results which he obtained in a surgical way. In regard to practice of an obstetrical character, I may say that this is an important matter. I make no allusion now to the puerperal state, wherein we may have indications of pathological conditions, but I allude to parturition. I always wash my hands thoroughly before an operation, and I usually employ antiseptics. If the nurse asked me if I wished to use an antiseptic solution, I would say: 'Yes,' with thanks. If nothing is said, I do not use it. I am particular to wash my hands very clean. I carry in my case the bichloride and carbolic acid, but in three cases out of four I make no use of them. I have in my private practice for a number of years seen no evidence of septic infection. My practice in the hospitals is different. The conditions and circumstances and surroundings are different, and I feel called upon to exercise still greater precaution. Now, I believe that we ought to exercise unusual care in the hospital, but what I have been alluding to in my remarks just made is to practice of a private nature, and you have the *modus operandi* in those cases."

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THIS led to a little controversy of harmless proportions between Dr. Harvey and Professor Leavitt. Dr. Harvey thought when a physician had positive opinions on a subject he should say "yes," when he means it, and if he thinks a thing is not necessary say "no," with thanks. To which Professor Leavitt replied: "As I said, my opinions on this subject are not very positive, I am only giving my practice."

Dr. Hingston spoke of the difficulties of the country practitioner in securing even ordinary decency. He said: "I have been called into places where I would gladly have stayed out, where there was neither fame nor name. We find when we look around for a nurse, one of the same class as the patient; when we wish to give any instructions as to work we find that no matter how instructions may be given, or how particular we are, our words are entirely neglected; we find that when we ask for a syringe it is black with filth; we find when we ask for a basin to wash our hands it is one of those tin pans used in the kitchen and all broken to pieces, and a poor piece of tin at that; and, when I have looked upon

these things, it is often a question in my mind whether we should do anything at all. We should just wait and watch."

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**D**R. P. J. B. WAIT said: "We must remember that there are many things to be learned from experience—both our own and that of those who have gone before. The fact remains after all our talking about antisepsis that our grandmothers and our mothers had families of six to ten and even up into the teens, and they lived, and the children lived, and the doctors who attended them had never seen a fountain syringe, had never heard of the bichloride, and the disgusting smell of carbolic acid was unknown in the world. I suppose there is not a gentleman in this room who does not believe that cleanliness is next to godliness. When I began the practice of medicine I understood that. I have had no case of septic poisoning, and I have used no carbolic acid or bichloride. Among the well-to-do I can have cleanliness and more comfort, but I dare not say I have had any better success among the rich than among the poor."

Dr. Richter said: "I am very desirous of hearing the end of Dr. Hingston's story; and I have just asked him if he was troubled, in those cases to which he has so graphically referred, with peritonitis and other diseases, and he says no. Now this is enough to shatter the rankest bacteriologist. I was in hopes when I came here that I would gain some knowledge of whether this World's Congress believed in the germ theory as the cause of disorder, but the discussion seems to wander over a large territory."

Dr. Geo. B. Peck thought that the last speaker treated this subject with something like levity. "I didn't quite catch the drift of his remarks; however, what I did get of them reminded me of that great American humorist, who, when he announced his subject, never referred to it again during the whole lecture. In regard to asepsis, I have seen many cases which occurred where the conditions were as bad as they could be, and no bad results occurred. Now that may be owing to our atmosphere. In our climate microbes don't grow perhaps. However that may be, I don't know. I never in my practice of obstetrics use the vaginal douche unless there is some call for it."

**D**R. JOHN C. BENNETT said: "I must apologize for speaking here, but I cannot refrain from saying something in the face of these remarks, which seem to leave the impression that we as physicians are allowing ourselves to stand in the face of the facts which are taught us by bacteriologists. Now then, if these men who have spoken to-day knew what has been accomplished in German hospitals in the way of antiseptis, they would be friends of antiseptis. I am a friend of antiseptis, and there are cases in which antiseptis must be practiced in order to obtain asepsis. Take the germ of cholera and put it in gelatine, and the germ can be produced and reproduced. Now then, because the poor don't suffer is no argument whatever against antiseptis."

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**D**R. MARTHA G. RIPLEY said "that the practitioner who came from a case of erysipelas has no business in the obstetrical room. The younger men and women may learn something from the practical experience of others who talk to them. There is something to be said for the country practitioner in the way of good air, which in crowded cities we don't get. If I could choose my patients, I would have their surroundings cleanly, and the best of nursing, the best of care. But in general practice we must do the best we can. I think we forget that an obstetrical case is not necessarily a pathological case; that it is physiological. I live in a city where I presume that two-thirds of the women are attended by midwives. We have a large Scandinavian element, and they rarely ever call in a physician. They have no antiseptic precautions.

"Now in the Maternity Hospital, of which I have charge, there are hundreds of women and almost up into the thousands who have been confined within very few years, and we have not had a single case of sepsis. Now I treat the case according to common sense—my idea of common sense. My hands are clean, the nurse's hands are clean, not necessarily with bichloride, although we have it. No antiseptic treatment is given at all unless there is a bad uterus. Then we cleanse it."

Dr. Fordham of Zurich, Switzerland, said: "Fifty years ago it was better for a woman to be confined in a gutter than to be con-



fined in a hospital. In our days things have changed. It is better for a woman to be confined in a hospital than at her own home. Why is that? Because we have found out the close relationship between the puerperal state and septic disease. If there is nothing in what we call antiseptics, if puerperal fever has been caused through the entrance of germs into the blood, then I say we are justified in every case in making a thorough investigation, and that investigation ought to be carried on by the board of health."

Dr. Frederick Becker said: "I am inclined to look at the case somewhat like our friend from Minneapolis. Lying-in is a purely physiological case. We have heard a great deal about the bright side of obstetrical cases. I have had, within the last two years, two cases where there was trouble. I found it was not due, however, to the lack of antisepsis, but in both cases could be traced to taking cold. Now we recognize the matter of a woman's keeping warm during the lochial period. We know as physicians the results arising from the suppression of this function, and I believe if we were as careful to keep our patients as warm as a great many are, I do not believe we would have one-half of the bad results we now have in practice."

Dr. Claudius B. Kenyon said: "I want to enter a protest against one point. My friend Dr. Roby makes a statement that the majority of the homeopathic fraternity do not believe in the germ theory of disease. If this is true, I feel sorry for the homeopathic profession. I simply wanted to make this point when somebody objected and said they ought not to go from a case of erysipelas to a case of confinement. Why does he object?"

Dr. Geo. B. Peck said: "I flattered myself that the members of this Institute read my paper carefully at their homes, and, if they have, they will find that I confined myself strictly to my subject, and furthermore, have said all there is to be said on that subject. I am well satisfied of the truth of the germ theory of disease. I wish it was absolutely demonstrated, for in the practical working of the germ theory I find the strongest proof and the best explanation of the cure of disease I have found anywhere. The profession, as a whole, believes thoroughly in aseptic precautions. This is to say, at least three-quarters, as was indi-

cated by the statistics which I presented last year, when this subject of the germ theory came up. I objected to the use of corrosive sublimate on chemical grounds. The instant that substance comes into the presence of the liquid albumin, it forms an insoluble precipitate. That being the case, I have no use for corrosive sublimate in a vaginal douche. It has been stated that the testimony of city doctors who enjoy select practices has been given here. I am a city doctor, and I defy anyone, unless it be someone who has practiced in the neighborhood of Five Points in New York, to have a meaner class of patients than I myself have in regard to one certain class of them. For some years I have been city physician simply because, if I resigned, an allopath would be appointed in my place, there being no homeopath in the district qualified. I have been in places that no one cares to go, and I never lost a case or had any serious trouble, or any germ diseases among those people. But that does not shatter at all my belief in the germ theory, because the people I find there are a class who enjoy perfect health, and I have no fears for their safety. The matter of putting pure bacteria into the perineum is another proof of the truth of bacteriology. It will produce natural results. Its excreta, whatever they may be, depend upon the individual, and upon the species. It doesn't make any difference whether the poison is due to the presence of bacteria or the results of their presence. If we use disinfectants, they should be mild and unirritating, and of those there are plenty."

Dr. Reuben Ludlam said : "I want to say just one single word. My brother from Rhode Island, although he comes from Providence, has raised old Harry here and got us into a peck of trouble."

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A MOST interesting paper, covering a very wide range, was read by Professor Sheldon Leavitt, entitled, "The Year's Progress in Obstetrics." In opening the discussion Dr. Martha G. Ripley said :

"I wish to say that within a year or two I have had what I consider a very important method of using the forceps. I have never seen it mentioned in any work ; in fact, it is directly in opposition to the rules that were given me for the use of forceps. In my obstet-

rical box I carry two sizes of forceps, the medium and the short, the very small. I have those small forceps with me at every case and in cases where I fear a laceration of the perineum ; when the head bulges on the perineum I fear a laceration of the perineum, and when I come to that point I stretch it. If I fear that the outlet is not sufficiently large, and I judge it impossible for the head to pass, then I take my scissors and make the last operation spoken of on each side. When there is any pain and the ligaments are stretched, I make a cut on each side from a quarter to half an inch, as I think best, putting in fingers as they are needed. That is very much better than a laceration of the perineum. I like that operation very much, in case I fear that there is to be a laceration. Now, to avoid a laceration, I have worked over the perineum and stretched it and dilated it as much as possible ; then, when there is no pain, I put in my small forceps. If a pain comes, I stop. I work when there is no pain, when every part is relaxed. I can get then the best results. I have tried it in hundreds of cases, and I can avoid a laceration of the perineum many times, and if I delivered with the forceps when there was pain, I would get laceration. I will say this, the patients are not frightened by the word forceps. I will say I have a little pair of spoons here that will help. It will shorten the operation. I think mine are the Higbee forceps, the smallest size you can find.

"It has been said that you can use large forceps as well. I want to say that sometimes I can get along better without any forceps, but when you depend upon delivering without the pain and expulsive efforts of nature, you have got to use a little force. Sometimes I get along without using any forceps. You cannot use force without pain."

Dr. Hingston said : "Almost the last words of one of the doctors who spoke on antisepsis was that he believed that it was almost a rule rather than the exception that obstetrical cases were attended without any care as to asepsis. Now, in my discussion of the paper before this, I rather supposed that the people here thought that I was one of that class, and I don't believe I look like a very dirty man. I am heartily in concord with the opinion that the greatest aseptic condition should be adhered to, and when I remarked that I thought it was perhaps better to stay out of the

vagina than to go into it under certain circumstances, I don't want to be understood that that was my method. On the contrary, if I had had time to finish, I would have said that after I go away from my cases I insist that the nurse shall leave them alone, keep out of that domain. I permit none of these antiseptic washings, that we have seen recommended in the journals and elsewhere, to be carried out every day or twice a day. On the contrary, I believe that if we do not have trained nurses, we had better keep the nurse away from that domain. Let us make the vagina as aseptic as possible. Let us be as cleanly as we possibly can. These are my views upon this subject, and I was glad that this paper came up after the other one, because I felt that I was misunderstood; but as I believe there are more ways of killing an ox than choking him with butter, I have now got in my say."

Dr. Henry E. Beebe said: "The measures recommended are all very good, but I think it is quite well proven that of later years laceration of the perineum is more frequent when the shoulders are passed than when the head is passed."

Dr. Fielding L. Davis said: "In my practice as an obstetrician I have delivered several hundred. I just want to speak with reference to the use of forceps. In using the forceps it has been my practice not to take hold of the forceps until the head was fully born. It allows control of the head as it approaches, and it is not possible for you to protect it in any other way."

Dr. Sheldon Leavitt, in closing the discussion, said: "I have nothing of importance to add that occurs to me. I might say a few words with regard to the use of forceps as mentioned, more especially by Dr. Ripley. These short forceps, these very short forceps, are a convenience, to say the least. The use of emollients as mentioned by Dr. Ripley is an excellent practice. But we must give what Graves demanded—the tincture of time, in which to accommodate itself to the size of the fetal head. But the cases of which I spoke, in which episiotomy is desirable, are those in which we have given the time, and the vulvar opening is hard and unyielding, and the head out of proportion to it. Under those circumstances where laceration is received, from the experience which we have had, we may introduce the scissors and make the incision to which I have alluded."

THE remaining papers of this section were, "Puerperal Fever," by Dr. J. B. Gregg Curtis, "Puerperal Eclampsia," by Dr. Lemuel C. Grosvenor, and "Puerperal Insanity," by Dr. M. D. Youngman. In the discussion Dr. Grosvenor said :

"I want to add just a word to this last paper in regard to feeding. A few years ago one of our professional brothers sent for me, and I went there to assist. The patient believed everybody was trying to poison her. We gave her oyster broth, milk, soups, gave her good square meals every day ; but the third morning she looked up when we were making preparation for her meal, and she said : ' Well, I believe I will take my breakfast in the old way this morning.' I speak of this to emphasize what the doctor said in his paper."

Dr. Yeomans of Clinton, Ia., said : "In replying to 'Puerperal Insanity,' I cannot quite agree with the doctor that it is the result of sepsis always. It brings one case to my mind, where one patient, for four successive times, became insane about the third month. She came under my care during the third time. I think I was able to ameliorate her condition very materially, but she had little confidence in women doctors, and especially in homeopathic women doctors, and through a combination of influences my patient was wrested from my hands. Her child was neglected, as all her children were ; for the want of a mother's care they had died in early infancy, and she was moved to an asylum, and what became of the woman I do not know, but there was no septic influence, so far as I was able to detect. I could detect no uterine lesions. There seemed to be some influence affecting the nerve centers that I could not really explain myself."

Dr. J. B. G. Custis said : "I do not know that I have anything further to say except that on the matter of contagion it has always been my practice, until this winter, when I had a very peculiar experience. I had a case where traumatism was the result of a fever, and the first thing I knew, I was in the case without knowing it until I got in the room, and the case was so urgent that my attention was demanded. Then there was another case that I referred to in the paper, of diphtheria. Accidentally, without anybody's fault at all, that room was used for a confinement case, before the first patient had been out of it five days. So I came

to the conclusion that in this disease we have one that is contagious to the highest degree, that the disease can be contracted through the larynx, stomach, or any other organ, and that it is almost impossible for a physician in attendance upon such cases to rid himself of the poison while thus coming from other cases."

Dr. S. W. S. Dinsmore said: "Dr. Grosvenor did not mention, at least I did not hear him mention, *veratrum viride*. I will just say, in regard to puerperal fever, that I was unfortunate enough a few years ago to have five such cases inside of ten days, and after that siege was over I did not attend any more for a long time. After that I did not see a case that I thought was carried directly by the physician."

Dr. Yeomans, Clinton, Ia., said: "I have had quite a number of cases of puerperal insanity, and I just want to say that I have had excellent results with hyoscyamine, and when I hear this subject spoken of that remedy always comes to my mind, and I find that it is an almost invaluable medicine."

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## ● GOLDEN GRAINS. ●

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—A YOUNG woman living near Blairstown, N. J., is reported to have given birth recently to quadruplets, two boys and two girls, all alive and apparently well. As the mother is but sixteen years old, and this is her first venture, the prospects of her having a large family seem to be good.

—DR. FRANK KRAFT says that on all the shores of all the seas there are not two grains of sand formed alike. But the allopath believes that the human machine is similar in all; so he pours his unknown medicines into all alike.

—DR. L. C. M'ELWEE says: "Of all the palliative measures in croup I think trypsin the most reliable, the quickest, and most natural. It is not medicinal, clears away the obstruction quickly, and does not change the symptoms."

—DR. W. TOD HELMUTH says that children suffering from incipient spinal disease often have such pronounced gastric symp-

toms that valuable time is lost in treating these stomach symptoms. These cases are usually characterized by flatulence, nausea, vomiting, and a capricious appetite.

—DR. JOHN H. CLARKE, in *Homeopathic Review*, reports the case of an unmarried woman, about thirty-three, of a tuberculous family history, who had had lupus for many years, and was much disfigured, part of the nose having been eaten away, the nostrils being blocked. Tuberculin (Heath) 200 and 1 m. one dose every ten days, was given, with complete and lasting cure.

—DR. JOHN M. SCUDDER says that, while much is written about bathing and the benefits to be obtained from the bath, it is necessary to prefix a caution and say that the life may be washed out of the feeble, and what was intended to be a benefit will really destroy. This is especially the case with infants and children, and I have often been obliged to stop the prolonged and frequent bathing to which they are subjected.

—ONOSMODIUM VIRGINIANUM is a remedy having direct application to the sexual sphere of woman. Among the general symptoms is great muscular weakness, a tired feeling over the entire body. The muscles feel treacherous and unsteady, as though one did not dare to trust them. While this feeling is general, involving all the muscles, yet it is particularly noticeable in the legs. The gait is unsteady, the calves numb, the sidewalk seems too high, and the jar of walking causes headache.

—DR. G. BETTON MASSEY says that, when a diagnosis of displacement has been made, it is an error to assume that the proper course to pursue is to correct the malposition by placing within the vagina a skeletal structure never contemplated by nature. The displacement has been caused by some other condition, and no cure can result until that condition is first remedied. The causal condition in most cases is an enlarged uterus due to catarrhal or other inflammatory processes, and a true restoration of health may be obtained by remedies that correct this primal trouble. The use of artificial support within the vagina should be reserved as a last resort for incurable cases.

—MR. JONATHAN HUTCHINSON has brought forward the curious query, Do those who are seriously ill ever sneeze? He says he

does not recollect ever to have seen any but fairly healthy persons sneeze. He puts the question with especial reference to the widely spread popular superstition that sneezing is a sign of health and good luck. It is possible, he thinks, that this may have had its origin in the fact that it is for the most part an act restricted to those in fair health. Tylor, in his "Primitive Culture," gives interesting facts as to the prevalence of this creed, and as to certain customs associated with it, and traces it in part to doctrines of animism, but Mr. Hutchinson thinks the suggestion he has given may also have some value. .

—A MOST significant thing in gonorrhea in women is the vulvo-vaginal gland situated near the junction of the lower end of the labium minor with the labium majus. When one can see a little red circle around the mouth of Bartholini's duct, it is suspicious; and when one can squeeze some yellow pus out of the duct, it is almost certain to be gonorrhea; the gonococcus has penetrated the duct and attacked Bartholini's gland. We have no better guide to gonorrhea than Bartholini's gland. I have now examined so many, with confessions and non-confessions, and noted results, that I would say that if pus can be pressed out of both ducts ninety-nine cases in a hundred are gonorrhea. So chronic catarrh of Bartholini's glands is pathognomonic.

—DR. MORRISSON, in *Homeopathic Review*, details a case of carcinoma of the breast, in a woman aged forty-six, cured by arnica. The prescription was based on the bruised character of the breast pains; upon the position of the tumor, as being the most likely spot for injury, and upon the results of treatment in a similar case some eighteen years since, this former patient being still free from any trace of the mischief for which the knife had been recommended. The treatment with arnica was begun with 1 x, and a lotion of 20 drops of tincture to 4 ounces of water. As the breast improved the remedy was given successively, during six months, in 2 x, 3 x, and 200. At the beginning of the treatment there was considerable cachexia; the patient's general health was low; there was pain and dyspnoea; the infiltration of the glands was marked, and there was weakness of the left arm. Mr. Knox-Shaw confirmed the diagnosis.



—AMMONIUM CAUSTICUM, said a speaker at a recent meeting of the Missouri Institute of Homeopathy, speaking of croup, brings up the rear of this procession of pitiable conditions, with all its saddest phases. The voice is extremely feeble or the aphonia is complete. The patient, like the voice, is weak. The cough, which is not now painful from benumbing of the parts, is accompanied by expectoration of mucus, especially after drinking. As the downward trend of the failing forces continues, respiration becomes more and more labored and the ominous rattle and stertorous breathing supervene, spasms of the chest muscles announce the fact of final suffocation. Too bad that such a picture was ever beheld by human eyes. We have seen it though, but not often. The drug picture adapted to the disease likeness will work magical changes. If the case have gone so far as to be beyond reclaiming, the administration of the similimum will rob the closing scene of its ghastliest terrors, will lead the struggling creature with gentle touch beside still waters to lie down in the green pastures of euthanasia, fearing no evil. If the condition be less severe and the vital forces have power to rally, the similimum will guide their wandering feet back to the highway of health, amid the plaudits of wondering friends and gladsome hearts.

—DR. GEORGE CECIL says that a striking feature of the mutability of times and minds is the rapid growing distrust of antiseptics. A new antiseptic idol is no sooner set up than it is thrown down and broken. The simplicity of the master operators is simply admirable. The only two agents that defy the attacks of time and the idol breakers are soap and water. The sterilization of instruments, hands, dressings, etc., is so simple that no one should err. The germicidal agents that for years have been deemed indispensable now either play an insignificant rôle or are consigned to the limbo of not only useless but harmful trumpery. Our best lessons, truly, are learned through our mistakes. Another, and hardly less important lesson, in the after management of surgical cases is the almost universal abandonment of the use of opiates. Very few cases are benefited by or really demand the hypodermic use of morphia, that for a long time was so generally

administered. Some of the reasons that condemn its use are prolongation of the nausea and vomiting from the anæsthetic, the delay of prompt reaction, the arrest of the secretions, and the masking of important symptoms as they may arise. Nature untrammelled is the best restorer. Quite a lengthy article might be written upon the abuse of opium, or the advantages of not using it in surgery.

—THE following was reported by Dr. Springle in the *Montreal Medical Journal*, June: "Mrs. M., aged twenty-seven, Irish, had always enjoyed fair health to date of marriage, four years ago. She was delivered of a large child after a long, tedious labor, with instrumental aid. Since that time she has aborted twice at the third month, suffering greatly before each mishap with pelvic distress and pain. In the intervals she did not complain either of pain or disordered menstruation. In December, 1891, I attended her for her third abortion, which was complete when first seen. On vaginal examination, the following peculiar condition was found to exist: The posterior vaginal wall was raised by a tough fibrous cord, in a tent-like manner, to the anterior lip of the cervix in front of the os, leaving an aperture on either side, through which the finger could explore the parts beyond. The adhesion measured about one-eighth of an inch in diameter at its attachment to the cervix. At the time, the uterus appeared to be held down by this band. The patient made a good recovery, and the adhesion was subsequently divided. Adhesion in this case probably was the result of her first confinement. Whether the condition was responsible for the repeated abortions, I am unable to say positively, as she has not become pregnant since."

—PROF. THAD. A. REAMY recently operated at the Good Samaritan Hospital, Cincinnati, on a woman for ovarian and tubal disease causing uterine hemorrhage and pain. The patient was twenty-eight years old, the mother of two children, and had suffered for seven years, except when pregnant, from menorrhagia, the period being profuse and prolonged to ten or fourteen days, with much pain in ovarian region, on both the right and left side. Before the operation there was found a fluctuating body apparently as large as a turkey's egg, to the right of the uterus, movable

and tender on pressure ; and continuous with it a distended Fallopian tube. On the left side the same conditions existed to a less marked degree. Both ovaries and both tubes were removed, The entire ovary was soft, not much ovarian stroma being left, the mass consisting of one large cyst and many smaller ones. In that portion of the broad ligament which was removed was a commencing intra-ligamentous cyst, about three-fourths of an inch in diameter. The uterus was enlarged and anterioted but free from tumor, a rare occurrence when uterine hemorrhage is so important an objective symptom.

The abdominal toilet was made by passing a small soft sponge, wrung out of warm water, into Douglas' pouch, cleansing the cavity and leaving it dry ; no flushings were used. The incision (three inches in length) was closed by drawing the cut edge of the peritoneum, on each side, over the cut edge of the abdominal wall, and securing by fine silk sutures, passed as close to the margin of the wound as possible. The wound was then covered with narrow adhesive stripes, a small pad of cheese cloth, then a broad pad, and finally a cheese cloth bandage ; no antiseptics of any character being used. Prof. Reamy relies exclusively upon cleanliness, and uses no chemical agents of any kind in his operations, either in the water for flushing the cavity or in the water in which the sponges are cleansed. And although performing laparotomies in the general operating amphitheater where general surgery of every character is extensively practiced, and in the presence of students fresh from the dissecting room, he has immunity from those complications which are said to delay convalescences where antiseptics are ignored.

—THE well-merited sentence and imprisonment of Dr. Sara B. Chase, a graduate of the Cleveland Homeopathic Medical College, give special pertinence to the following remarks recently made in the London *Lancet* : "As is well known, in England and in Ireland the punishment is penal servitude for life, or for any less term, or imprisonment ; while if the mother of the child should die in consequence of this unlawful act, the crime becomes constructive or legal murder. In 1875 Alfred Thomas Heap, a Manchester abortionist, was convicted of the murder of a woman. He had used a Manchester spindle, with which he had transfixed the

gravid uterus. He was found guilty, but was recommended to mercy by the jury. As, however, they were unaware that he had already served five years' penal servitude for procuring abortion, the recommendation was disregarded and he was executed. Since then there have been many convictions and heavy sentences, but still the crime goes on. In Scotland the punishment is arbitrary ; in France, Spain, the German Empire, Austria, Hungary, Italy, Russia, Norway, Sweden, and Denmark—in short, throughout the whole of Europe—the crime is punished with imprisonment for from six months to twenty years or for life. In Sweden the penalty is death if the mother dies, and in Russia the mother, if a consenting party, may be exiled to Siberia ; in the Dominion of Canada the penalty is imprisonment for life ; in Nova Scotia, Quebec, Ontario, British Columbia, and in Prince Edward Island it varies from imprisonment for two years to for life ; in New Brunswick the penalty is death ; in Australia and New Zealand the punishment is very severe, ranging from two years' imprisonment to penal servitude for life ; in the United States it is punished with fines ranging from one hundred dollars to five thousand dollars, with imprisonment of long periods, and with death ; so that in all parts of the civilized world this crime is regarded as a grave one, and is punished with more or less severity. Every medical practitioner who may have the opportunity of doing so should aid in bringing to justice the miscreants, both male and female, who live and thrive on this abominable trade, too often at the risk of the lives of the unhappy women who resort to them."

—A WRITER in the *Therapeutic Gazette* reports the following interesting observations on the purgation of sucklings by drugs administered to the mother :

"1. *Senna*.—Eleven observations. In eight cases the compound licorice powder was administered, and in three the confection of senna. The licorice powder was given in teaspoonful doses, for the most part once a day, but occasionally oftener. In one dram of the powder there are ten grains of senna and five grains of sublimed sulphur.

"In no case was the child purged by the use of the drug, which, in the majority of cases, was given in sufficient quantity to bring about a daily action of the mother's bowels.

"2. *Aloes*.—Ten observations. In all cases the pill of Barbadoes aloes, combined with a quarter of a grain of extract of nux vomica, was administered. In five cases this pill was given twice a day, and in five only once a day. The amount of Barbadoes aloes contained in each pill is 2.18 grains. In eight cases the children's bowels were unaffected. In one case the child's bowels, which had previously acted every day, became somewhat more costive, and in one case the child's bowels acted more freely (twice a day instead of once a day). In this latter case it will be observed that the pill was taken twice a day.

"3. *Cascara Sagrada*.—Ten observations. In seven cases the liquid extract was administered, and in three the solid extract. The liquid extract was given in  $\frac{1}{2}$  dram doses, combined with carminatives, three times a day. The solid extract was given in 2 to 5-grain doses twice a day. In eight cases the children's bowels were unaffected. In one case the child became more costive, and in one case less costive than before.

"4. *Sulphate of Magnesium*.—Eleven observations. In all cases 1-dram doses of sulphate of magnesia were administered three times a day. In five cases the children's bowels were unaffected. In five cases the bowels were more freely open than before. In one case the child's bowels became more costive."

—DR. H. J. BOLDT says that: "A mistake, which, to my knowledge, is committed occasionally, is confounding a *distended bladder* with an abdominal tumor. I have been called in consultation several times when such error existed. A most interesting case of this description is the following: On March 2d a woman, æt. thirty-two, was sent into my service in St. Mark's Hospital, with the diagnosis of pregnancy in the fifth month, complicated with an abdominal tumor and ascites. She had been under the doctor's care for three weeks and was gradually getting worse—hematuria also being present for several days—so that it was thought that no time should be lost in opening the abdomen. It was stated that incontinence of urine existed.

"When seen by me, the first thing noticed was the putrescent septic odor emanating from the patient; great emaciation, and pinched features; the abdomen distended to its utmost, the skin glistening from the effect of distention. External appearance,

palpation, and percussion showed nothing different from the characteristics of excessive ascites. The vaginal mucosa protruded slightly to the exterior; vaginal examination showed this to be due to a tumor crowding down the *cul-de-sac*. Anteriorly, there was also a decided fullness filling the pelvis.

"In making pressure with my finger anteriorly and upward, to reach the *portio-vaginalis*, a gush of dark-stained, and very putrescent urine came out through the urethra. The discoloration was due to an old hemorrhage in the bladder; it was therefore evident that the bleeding had taken place some time previously, and also that the bladder was filled with urine; and it appeared therefrom that the cause why catheterization had not given any result was that an ordinary *female catheter* had been used. With a male catheter, the bladder was readily emptied; after about two quarts of urine were emptied, the contours of the bladder tumor could be seen, the summit a hand's width above the umbilicus. In all, 1664 c. c. [say 55 fl. oz.] of urine were withdrawn; which, as far as I am aware, is the largest quantity of urine ever found contained in the human bladder. Dr. Paul Mundé, who happened to be present, remarked: 'I have seen some greatly distended bladders, but never one which would nearly equal that.' This is certain, that it is almost impossible to conceive such possibility. Large sloughs of mucous membrane were thrown off when the bladder was washed out; and free hemorrhage again took place from the relief of pressure—the over-distention previously having compressed the vessels. Copious use of hot water, however, had a tendency to check the bleeding. It was impossible to reduce the incarcerated gravid uterus; and, consequently, I produced an abortion at once, and emptied the uterus completely under anæsthesia, then lightly packed its cavity with iodoform gauze, after making another unsuccessful attempt to reduce the displacement. A later attempt again proved unsuccessful. The patient died ten days afterward, from the result of the injured bladder, necrotic cystitis, and nephritis. Hence the necessity, when examining abdominal tumors, to invariably first see that the bladder is completely emptied."

## NOTES ON CURRENT LITERATURE.

## LEPROSY.

A WELL-WRITTEN and deeply interesting volume, on the causes of an increase in leprosy in various parts of the world, has appeared from the press of Swan Sonnenschein & Co., London. Its author, Mr. William Tebb, is a well-known and indefatigable traveler, who has probably seen more of the world, in the course of the last twenty years, than any other living person, with perhaps a half dozen exceptions. Mr. Tebb is an observing traveler. In fact it may be said that he travels primarily for the sake of the knowledge to be acquired. And any reader of his book<sup>1</sup> will speedily come to the conclusion that he has availed himself with great assiduity of his opportunities for observation. He has collected a great deal of information concerning leprosy; and he marshals his facts in such a way as to make them very interesting reading. As a vivid exposition of a terrible disease, it should receive the cordial attention of medical men everywhere. Leprosy is not a very live question in the United States, but there is much more of it hidden away in unsuspected nooks and corners than many of us are aware of; still, while we have little of it now, it is impossible to tell but that presently we may have more. The experience of Hawaii should open our eyes to at least the possibilities of the future.

Mr. Tebb's book is largely an array of unquestionable facts, and as such is a fearful indictment against the system of arm-to-arm vaccination. The author furnishes evidence of a convincing character that leprosy is being widely spread, in more than one country, as a probable result of vaccination. The argument may be briefly stated as follows: (1) that leprosy is not contagious, that is, it is not communicable by contact with the outer surface of the body; (2) that it is inoculable, that is, it may be propagated by the insertion of its virus beneath the skin; (3) that there has been a remarkable increase of leprosy of late years in many quarters of the world; (4) that any inoculable disease is liable to be propagated by vaccination; (5) that leprosy seems, in its late recrudescence, to have followed on the heels of vaccination, and especially of re-vaccination; (6) that this reappearance of leprosy as a widespread disease is probably not only *subsequent* but also *consequent* on vaccination. Every open-minded and

<sup>1</sup> THE RECRUDESCENCE OF LEPROSY AND ITS CAUSATION.—The Leprosy Commission Report, etc. A popular treatise, the result of personal inquiries made in the West Indies, British Guiana, Venezuela, the Sandwich Islands, Ceylon, South Africa, and Australasia. By WILLIAM TEBB, F. R. G. S. With an appendix, showing the results of vaccination. London: Swan Sonnenschein & Co., Paternoster Square, 1893, crown 8vo, pp. 412. Price six shillings.

rational person who reads these pages will come to the conclusion that a very strong case of probability has been made out.

The book is one which ought not, and indeed cannot, be ignored by medical men and sanitarians. It is the only full exposition of the subject which has ever been made, and the world owes a debt of gratitude to Mr. Tebb for the painstaking and conscientious manner in which he has fulfilled his task.

#### INTERNATIONAL CLINICS.

THE series of volumes issued by J. D. Lippincott Co., under the general title of "International Clinics," continues to maintain the excellent standard which has won for it so many encomiums. Four volumes of the second series have now been issued, and contain material of great value to every practitioner. It is hardly possible to find anywhere in the same compass such a remarkable series of essays on timely topics. This series of volumes gives in a compact and handy form the original researches and clinical experiences of the leaders in the profession. In the special department covered by this magazine the papers are of particular value. In the first volume will be found papers by Dr. Paul F. Mundé, Dr. F. Forchheimer, Dr. Charles F. Parkes, and William Goodell; in the second volume, by J. Bland Sutton, Roswell Park, Alexander J. C. Skene, Barton Cooke, and Hirst; in the third volume, by Charles J. Cullingworth, Henry C. Coe, and John C. Shaw; in the fourth volume by Dr. Rickman, John Godlee, Dr. W. W. Keen, Dr. Robert Abbe, Dr. Edward P. Davis, and Beverly Robinson. Many of these papers are elaborately and beautifully illustrated by the photogravure process, while the letterpress, paper, and binding do credit to the well-known house by whom they are issued. The small price asked for these works brings them within the reach of every practical physician, and no one who desires to keep up with progress in therapeutics can afford to do without them. They have all the freshness of magazine work, while, being in the form of bound volumes, they make a permanent addition to the working library. All that we have said in regard to the first series as examples of what medical literature should be, might well be repeated in regard to these, and we most heartily commend them to our readers.

<sup>1</sup> INTERNATIONAL CLINICS, a Quarterly of Clinical Lectures on Medicine, Neurology, Pediatrics, Surgery, Genito-Urinary Surgery, Gynecology, Ophthalmology, Laryngology, Otology, and Dermatology, by professors and lecturers in the leading medical colleges of the United States, Great Britain, and Canada, edited by JOHN M. KEATING, M. D., L. L. D., Colorado Springs, Col., JUDSON DALAND, M. D., Philadelphia, J. MITCHELL BRUCE, M. D., F. R. C. P., Aberdeen, Scotland. Volumes I, II, and III, Second Series, Philadelphia: J. D. Lippincott Co., 1892. Volume IV, Second Series, Philadelphia: J. D. Lippincott Co., 1893.



## THE TISSUE REMEDIES.

WHEN Schüssler first introduced the idea of tissue remedies he suffered from the same inertia that meets everyone who attempts to introduce a new idea, but gradually the question as to the value of these remedies is settling itself. They have been adopted into the practice of many of our ablest men, and, although perhaps few use them exclusively in the sense in which Schüssler indicated they must be used, still they have won favor from many who treated them with derision when they were first announced. It is not probable that tissue remedies, so-called, are sufficient for all purposes in practice. There are many cases in which they do not seem to be indicated; nevertheless they do fill a wide field, and only need more thorough and systematic proving to become of the greatest value. The work,<sup>3</sup> "The Twelve Tissue Remedies," has been recently issued with thorough revision and enlargement at the hands of Drs. William Boericke and W. A. Dewey, and they now form a handsome octavo book of nearly four hundred pages. That a work of this kind should have passed through three large editions in five years shows the interest which the profession takes in it. The present volume is very conveniently arranged, with large well-spaced type, and gives the essential characteristics for which the remedies are indicated. Even those who possess the earlier editions of this work will find this third one a good investment. Special commendation may be given to the Repertory, which occupies nearly one hundred pages and is arranged in a very convenient form. The publishers are to be congratulated upon making so handsome a book, and we trust it may meet with a wide sale.

## RINGWORM.

WE are accustomed to receive, at intervals of a few months, a little brochure from the fertile pen of our good friend, Dr. J. Compton Burnett.<sup>4</sup> Last year we had his work on the cure of consumption by its own virus. Now we have a work of similar size on the constitutional nature and cure of ringworm. Dr. Burnett, like most thoughtful homeopaths, believes that skin diseases have as a rule a constitutional basis. As he says, "Gout in the big toe is not a disease of the said toe; acne on the shoulders

<sup>3</sup> THE TWELVE TISSUE REMEDIES OF SCHÜSSLER, comprising the theory, therapeutical application, materia medica, and a complete repertory of these remedies. Homeopathically and bio-chemically considered. By WILLIAM BOERICKE, M. D., and WILLIS A. DEWEY, M. D.. Third edition, rewritten and enlarged. Philadelphia: Boericke & Tafel, 1893.

<sup>4</sup> RINGWORM, ITS CONSTITUTIONAL NATURE AND CURE. By J. COMPTON BURNETT, M. D. Philadelphia: Boericke & Tafel.

of a young person is not a disease of the skin of the shoulder; neither is a yellow-coated tongue a disease of the tongue." It is undoubtedly true that ringworm is due to a specific fungus, but it is also true that the fungus will not grow except on a congenial soil. Dr. Burnett gives in his usual lucid and pleasant style a number of reasons for treating ringworm as a constitutional disorder. His methods of treatment, and the why and wherefore, we leave our readers to discover by reading the book for themselves.

#### DISEASES OF THE RESPIRATORY ORGANS.

PROFESSOR THEODORE INGALS has brought out the new edition of his well-known work on the diseases of the upper air passages. The present edition is very handsomely and profusely illustrated, and shows great care in its preparation. The present edition differs from the former one in more complete notes on ætiology, pathology, and symptomatology, and prognosis of the several diseases discussed. The book shows careful preparation, and, while of course we cannot commend most of its suggestions as to treatment, still those who desire to know what the regular school is doing with these diseases in the way of treatment can find it here stated succinctly and accurately.

#### PHYSICAL TRAINING.

No physician need be reminded of the value of physical training, and yet, when we see the results of training as evidenced in the athletic world, we are led to suspect that there is something wrong about most modern methods of physical culture. In fact, there is no doubt there is more straining than training in most of the popular systems of the day. Mr. Edwin Checkley, who is by profession an engineer, has given for some years past considerable attention to the subject of physical training. His ideas, which are given in his work, "A Natural Method of Physical Training," are at variance with the ordinary process in the gymnasium, but they are along the lines of physiological growth, and indicate a truly natural method. It is a natural method, because it requires no apparatus, no special place or time, and is adapted alike to the

<sup>5</sup> DISEASES OF THE CHEST, THROAT, AND NASAL CAVITIES. Including Physical Diagnosis and Diseases of the Lungs, Heart, and Aorta, Laryngology and Disease of the Pharynx, Larynx, Nose, Thyroid Gland, and Esophagus. By E. FLETCHER INGALS, A. M., M. D. Second Edition, Revised and Enlarged. With 240 illustrations. New York: William Wood & Co., 1892.

<sup>6</sup> A NATURAL METHOD OF PHYSICAL TRAINING. Making Muscle and Reducing Flesh without Dieting or Apparatus. By EDWIN CHECKLEY. With Numerous Illustrations by H. D. Eggleston. New, Revised, and Enlarged Edition. Brooklyn: William C. Bryant & Co., 1892.

young and old, strong and weak, and to men, women, and children. In a few bright and interesting chapters he tells how to carry the body, how to breathe, how to exercise the muscles and joints, how to avoid obesity, with some special advice as to physical culture in little children. It is a work that can be most heartily commended. Mr. Checkley's views are built upon practical, hard common sense. His system promises to give proper control of all the organs, and, without unduly increasing the size of the muscle, to make it elastic and capable of the greatest amount of work. After considerable experience in the use of this method, we heartily commend it and its author to our readers.

#### DOMESTIC GYNECOLOGY.

JUST how much may be expected from placing in the hands of the laity works like Professor Southwick's "Domestic Handbook of the Diseases of Women and of Midwifery" may well be questioned. A thoroughly educated woman might understand it and appreciate it, but, unless she is isolated from competent medical aid, she is not likely to find it of any practical value, while the elaborateness of the book and its general professional tone will keep it from being of use to anyone who has not already a good education. In other words, it is too bulky and cumbersome and technical for the ordinary reader, and hardly needed by those who might be able to understand it. Of Dr. Southwick's ability as a practitioner and a teacher there is no doubt, but we can hardly believe that this work will fill a long-felt want, as its author seems to hope. A less elaborate work would have been more useful, and, while the ordinary reader would get from the work the idea that its author is an erudite and accomplished practitioner, she will not be able to get anything more practical from it. Dr. Southwick labors under the same difficulty that everyone does who has taught a professional class for a number of years. He instinctively adapts his style to those who have made a specialty of medicine, and while his teachings are well adapted to the medical class of women, they are too technical for the average reader.

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—THE next annual class for instruction in orificial surgery will assemble in Chicago on the morning of September 4. It will have a four hours' daily session during the week. For particulars address Dr. E. H. Pratt, Room 56, Central Music Hall, Chicago.

<sup>1</sup> A DOMESTIC HANDBOOK OF THE DISEASES OF WOMEN AND OF MIDWIFERY. With supplementary chapters. By G. R. SOUTHWICK, M. D. Boston: Hygienic Publishing Co., 1892.

## A WORD ABOUT "CHILDHOOD."

DEAR DOCTOR: I began last year the publication of a magazine for parents. It is not a medical magazine, but it contains a great many articles which would be helpful to you in family practice, not only as giving you a clearer insight into the working of the child's mind, and thus enabling you to deal with it more intelligently, but also as opening the way to helping parents to avoid many of the causes of disease in their children. All of us see, in our daily rounds and family practice, frequent instances of unintentional wrong to children, arising from a misunderstanding of their needs. Possibly we ourselves do not always exhibit the highest wisdom in dealing with children. I can recall many instances in my own experience where I have not.

No one takes CHILDHOOD from a selfish motive, as they might possibly take some other magazine or periodical: for it does not set out to please the fancy of the reader, nor to satisfy his artistic sense in literature, nor to show him the way to secure more of this world's goods, nor to enable him to improve his own situation in life—neither in this world nor in the world to come. It has a purpose in being, but that purpose is not found in any of these things. It aims solely to lead its readers to devote themselves more assiduously to the interests of children as a whole, and of such children in particular as may be within their personal influence.

The articles in CHILDHOOD are all written especially for it by the best writers in this country and in England, as will be seen by reference to the advertisement of the magazine on another page. With the experience of the year I believe I shall be able to make the magazine much more useful in the future than it has been. Several new departments will be added, and the magazine improved in many ways.

If you have not seen CHILDHOOD send for a sample copy.

Fraternally yours,

GEORGE WILLIAM WINTERBURN.

THE MERRISON COMPANY PRESS, RAHWAY, N. J.

THE HOMEOPATHIC  
JOURNAL OF OBSTETRICS,  
Gynecology and Pedology.

EDITOR, GEO. W. WINTERBURN, M. D.

NOTE TO CONTRIBUTORS AND SUBSCRIBERS.

1. All articles or communications to this journal should be exclusively for its pages.
2. For the convenience of subscribers, this journal will not be discontinued until so ordered.

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A COMPARATIVE STUDY OF THE OPERATIVE  
PROCEDURES APPLICABLE TO THE COM-  
MONER VARIETIES AND DEGREES OF PEL-  
VIC DEFORMITY.

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BY

L. L. DANFORTH, M. D.,  
NEW YORK.

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**T**HERE is no subject in the whole field of obstetrics which receives so little attention in our society discussions as that of pelvic deformities. To the relative infrequency of these abnormalities as compared with other obstetrical complications may be attributed the neglect which this subject receives. Though seldom encountered in practice, we are not justified in totally neglecting this important branch of obstetrical study.

The writer has endeavored to ascertain the frequency of pelvic deformity in lying-in institutions in this country, wherever statistics have been published, and as a result interesting information has been obtained.

In a series of 2127 cases of labor in the out-patient department of the Boston Lying-in Hospital, Dr. Edward

Reynolds\* found 22 instances of pelvic deformity, and in 100 cases of confinement James W. McLane reports 10 cases in the first 100 cases of confinement in the Sloane Maternity.

In 3225 cases of confinement attended by students at the Lying-in Hospital in New York City, during the first three years of its existence, in only one instance was reduction in size of the fetus demanded on account of a contracted pelvis. In another premature labor was induced on account of a contraction of the pelvis in all its diameters; in not a single instance did the absolute indication for Cæsarean section exist from any cause. Pelvimetry is systematically employed by the students of this school. This is a remarkable record, and shows a much smaller percentage of cases of pelvic deformity than is generally supposed to be the case. Dr. Edgar states, with regard to the cases (1154) confined during the first two years in their lying-in hospital, in not a single instance did a markedly contracted inlet exist. He does not say that there were no cases of pelvic contraction to the minor degrees, and it is not assuming too much to suppose that some of the forceps operations and cases of version were performed on account of the small size of the pelvis.

In 250 cases of labor in private and consulting practice which the writer has recorded there were 3 cases of contracted pelvis—1 simple flat pelvis and 2 symmetrically small pelvises. The latter—the justo-minor pelvis—is the variety most frequently seen in women of American birth.

Among the 100 cases in the wards of the Boston Hospital, referred to in Reynolds' tables, there are 57 native women who presented one case of pelvic deformity, and that of a typical justo-minor type; the percentage of 1.75 per cent. being almost identical with that obtained among native women from the out-patient department of the same institution, and the obstetrical department of the Boston

\* "Transactions Am. Gyn. Soc.," 1890.

Dispensary, which was 1.6 per cent. In contrast to this the remaining 43 foreign women yielded 4 examples of the simple flattened pelvis (9.4 per cent.), and no justo-minor pelvis.

Among Reynolds' 2127 women of all classes 10.3 per cent. possessed contracted pelves of one variety or another. Abroad the average is about the same. Winckel says: \* "After all pregnant and parturient women were carefully examined as regards their pelvic relations, there were found among 1199 births 115 women with contracted pelves ( $9\frac{1}{2}$  per cent.), a figure which coincides exactly with those obtained of late years in the Werzburg Clinic (8.10 per cent.), and approaches closely to those obtained by Michaelis and Litzmann."

The first regular pelvic measurements were made in 1840-47 by Michaelis of Kiel, who found in 1000 parturients, 131 cases of narrow pelvis (10.3 per cent.). Litzmann (1848-86) found in 1000 parturients 149 (10.4 per cent.). Subsequent observers up to Winckel's time found a much smaller number of cases, but the difference is undoubtedly due to the fact that more than half the cases of slight narrowing were not recognized because they produced no difficulty in labor. Winckel concludes that "we shall not go too far in making the statement that contraction of the pelvis is present in ten to fifteen per cent. of all parturient women, but that usually only five per cent. are recognized even in clinical institutions on account of the effects upon labor." This would seem to be about the frequency in this country if we include all classes. Women of American birth are undoubtedly less frequently the subjects of pelvic narrowing than those of foreign birth. Furthermore, it may safely be concluded that an American birth decreases the amount of pelvic deformity among the children of foreign parents.

The predominance of the rachitic types of deformed pel-

\* "Text-book of Midwifery," p. 451.

vis, characterized by irregularities in shape of the whole pelvis, and especially by flattening of the inlet by undue projection of the promontory, among women of the lower classes born abroad, is probably due to insufficient nourishment and hard work before or during puberty.

The symmetrically small pelvis, due to simple arrest of development at puberty (a partial persistence of the infantile type), is the variety generally met with in some women of American birth and lineage, and is due, as might be expected, to the peculiar character and habits of American women and nineteenth century civilization.

In the practice of midwifery the following questions are now and then presented for solution:

1. Is there any external evidence, or anything in the progress of a labor in its early stage, which will enable one to suspect the presence of a pelvic deformity?
2. What constitutes pelvic narrowing, and how are we to determine that such a condition really exists, as well as the variety and degree of the deformity?
3. Is it possible to ascertain before labor sets in the relation of the presenting part of the child to the narrowest diameter of the pelvis through which it must pass to accomplish delivery?
4. Can we define with any degree of certainty the limitations of the different operative procedures by an approximate estimate of the extent of the narrowing?

I shall endeavor to answer these questions, *seriatim*.

First, with regard to the significance of physical peculiarities in pointing out the possible existence of pelvic deformity:

While narrow straight hips and short limbs may not prove to be indicative of diminished transverse and oblique diameters, the fact that such peculiarities of shape coexist should not be overlooked. As Spielgelberg says when he emphasizes the importance of making pelvic measurements, "Still, the other circumstances deserve that full weight be



given them, and even if they never afford more than certain *points d'appui*, suggestive to a certain extent of the direction in which measurements should especially be made, they nevertheless assist in deciding the best treatment for special cases."

An unusually short person, or a tall, slender woman with very narrow hips, or lameness due to diminished length of one leg; women with abnormal curvature of the spine, or undue hollowness of the back, which is usually the external evidence and accompaniment of excessive inclination of the pelvis: none of these peculiarities should escape the eye of the careful obstetrician. They may mean nothing, or they may be suggestive of more serious defects, the detection of which by more extended observation will enable one to act intelligently at the time of labor, and thus possibly save a life which without such preliminary knowledge might be sacrificed.

The life history of a woman with a spinal curvature, or other evidences of defective development, should be carefully scrutinized to ascertain if rachitis existed during childhood.

If physical peculiarities do not exist, or have been overlooked, the conditions revealed by an examination at the onset of labor may be of great value in pointing out the presence of contraction.

Failure to reach the presenting part, the non-descent of the head, and the resulting protrusion of the elongated bag of waters under the influence of the uterine contractions, and the imperfect adaptation of the head to the lower uterine segment, are conditions so suggestive of either an abnormal presentation or a pelvic contraction that a discriminating diagnosis should at once be made.

The occurrence of constriction or retraction rings after rupture of the membranes, without advance of the presenting part, is evidence of obstruction, and the continuance of natural labor under such circumstances only adds to the difficulties which already surround the case.

The symmetrically small pelvis (the justo-minor pelvis) has scarcely any external signs by which we may detect it, except, perhaps, narrowness of the hips, in a woman otherwise of normal proportions, though it would be more natural to suspect its existence in a very short woman. Rachitis, which causes the flat pelvis, or the generally contracted flat pelvis, does not always produce pelvic deformity in proportion to the intensity of the disease apparent in other parts of the skeleton, and sometimes it produces no pelvic deformity whatever.

A woman with a decided spinal curvature may have a perfectly normal or even a large pelvis, the location of the deviation of the bones being of more importance than the degree of it. Again, a woman may have a slight degree of pelvic deformity, and yet be delivered spontaneously and successfully, especially in a first labor, the ability or failure to do so depending upon the relation which the child bears to the contracted portion of the pelvis through which it must pass in order to be delivered.

Second. What constitutes pelvic narrowing, and how are we to determine that such a condition exists, as well as the variety and degree of the deformity?

One of the most important advances in the teaching of practical midwifery is in the direction of systematic examinations of the pelvis of pregnant women by means of the pelvimeter, the tape, and most important of all, by the hand of the examiner within the pelvic cavity.

Every physician who does much obstetrical work should familiarize himself in the first place with the shape of the normal pelvis, by examining the pelvic cavity carefully with regard to its sacral curve, depth of the lateral walls, and of the symphysis pubis, the inclination of the pelvis, and the degrees of objection of the sacral promontory.

External measurements are not of great value, because we cannot estimate exactly the thickness of the intervening bones or of the soft parts. Still conclusions can be

formed which will enable one to determine approximately the development of the innominate bones, and the width of the transverse diameter of the pelvic inlet. The same remark applies with equal propriety to the external measurements of the conjugate at the brim, which is taken from the spinous process of the last lumbar vertebra, to the upper border of the symphysis, and should measure not less than 17.5 cm. (or 7 inches) in the living subject.

The internal method with the left hand in the vagina is the method which gives the most accurate information, and the greater the contraction the more reliable is the result. This method is practiced as follows: With the fore and middle fingers of the left hand in the vagina the promontory of the sacrum is touched. Then keeping the middle finger on the promontory, press the side of the fore finger against the lower edge of the symphysis. The forefinger nail of the right hand is then placed where the examining hand is touching the symphysis. Remove the two hands together without separating them, so that the finger nail may accurately mark where the hand was in contact with the symphysis. An assistant then with a tape measure or rule measures the distance between the tip of the middle finger and the place where the side of the hand touched the lower edge of the symphysis. The distance is the *diagonal conjugate*, and it usually measures half an inch more than the true conjugate, which, as is well known, is four inches.

Now one would naturally suppose that a contraction of the conjugate below four inches must exist to constitute pelvic deformity. As a matter of fact, however, the conjugate may measure four inches, and if the other diameters are reduced so that the inlet is nearly round, as in the generally small pelvis (the justo-minor type), an obstacle to the progress of labor may be encountered at the superior strait. On the other hand, lessening of the conjugate at the brim to  $3\frac{3}{4}$  inches, or even to  $3\frac{1}{2}$  inches (Winckel), as in

the simple flat pelvis (the other diameters being normal), is no obstacle to delivery, and the deformity may remain unsuspected, although the mechanism of labor is generally altered. It is only in unfavorable complications such as would occur with a large fetus or an abnormal presentation, that serious disturbance of labor is observed.

In consequence of these peculiarities, some authors, and especially those who obtain the lowest percentages, recognize as abnormal only those cases in which arrest occurred in pelves where contractions were  $3\frac{1}{2}$  inches or less, while those who find deformity most frequent admit to their tables only those pelves whose conjugates are diminished by only one-fifth of an inch. For practical purposes we may say that dangerous contractions exist in the generally small pelvis though the conjugate measures full four inches, and in the flattened pelvis with ample transverse space when the conjugate is reduced to  $3\frac{1}{2}$  inches.

The difficulties met with in the delivery of a child through a conjugate of four inches in the symmetrically small pelvis may be explained by the fact that the transverse diameter in a pelvis of this variety is no longer, and may not be so long as the antero-posterior; hence diminution of the oblique diameter, and greater difficulty in effecting an entrance of the head than would be the case with even a shorter conjugate and more transverse space. Besides, in these cases the obstruction to labor is not limited to the superior strait, but continues through the whole pelvis. The mechanism is that of early and complete flexion, with occasionally a delay in rotation from decreased inclination of the inferior pelvic planes—and the increase in the length of the pelvic axis.

These remarks apply with almost equal force to the *generally contracted flat pelvis* as regards the obstacle to labor at the superior strait, since internal palpation shows the transverse space at the brim to be diminished almost as much as the conjugate. A generally contracted flat pel-

vis with an antero-posterior diameter of four inches is therefore capable of giving rise to as much difficulty as the symmetrically small pelvis of the same conjugate diameter. Normal labor is possible in either of these varieties of pelvis, though usually assistance by means of forceps is required. The characteristics of the *simple flat pelvis* is the shortened conjugate diameter, extreme contraction being uncommon, the length of the conjugate rarely falling below three inches. This diameter may not fall below  $3\frac{3}{4}$  inches, and when diminished to this slight degree only, labor may terminate without instrumental assistance, though version and forceps are alternative operations which often come into competition with each other.

*Third. The duty of the obstetrician, when confronted by a contracted pelvis, is to form as accurate an idea as possible of the type and measurements of deformity he has to deal with, and at the same time determine approximately the size, shape, and consistence of the infantile head.* If the gestation has advanced to full term, we know what the average measurements of the fetal head are at this time. But it is a matter of great importance to know in the particular case in hand what the relation of the head is to the pelvis, through which it must pass. Tables have been compiled which give the approximate weight of the child at different periods from the thirty-second week to the fortieth week, with the appropriate biparietal diameter of the fetal head at the corresponding periods, as well as the diminished conjugate diameters to which the fetus may be expected to adapt itself at these times. But for practical purposes such tables are useless. No one would ever be able to recall at the critical moment the information he desired, and if he could recall it the chances are that the knowledge would not be useful in solving the problem. We may determine the relative measurements of the pelvis, as well as the relation which the fetal head bears to the pelvic canal at its constricted portion, which is usually the conjugate of the

superior strait, by a very simple procedure. This maneuver may be resorted to during gestation, or when labor has begun at full term.

To secure this information, map out by external palpation through the abdominal walls the body of the child as accurately as possible. In the hypogastric region we search for the neck of the child, which is determined by the depression between the dorsal surface of the trunk and the region of the occiput. Then the head of the child is mapped out by bimanual examination, and to prove the correctness of the diagnosis, the head is made to descend slightly upon the examining finger within. If an assistant of intelligence is at hand, the external manipulation may be conducted by him. The head of the child is then made to descend by simultaneous pressure upon the breech and occiput. The hand within the vagina then ascertains whether the head really descends, whether it passes the promontory, or whether rotation occurs. Where serious obstacles are present it is easy to prove that the head remains with the greatest diameter above the pelvic brim, and even bulges out the region above the symphysis. Such a determination of the relation of the head to the pelvis is of decided importance in settling the time for the induction of premature labor in serious cases of pelvic deformity, especially when we are in doubt as to the period of pregnancy. Labor can be brought on when the head can be pressed into the pelvis no further than the vertex, and delivery will be accomplished too soon if the head is pressed into the pelvis down to or slightly below the parietal protuberances.

In case of an obstacle to labor at the superior strait, the gestation having advanced to full term, this method of determining the adaptability of the fetal head to the pelvic inlet may be of great service and enable one to choose between two or more competitive procedures. No great force is necessary to secure adaptation, and it need not be continued more than a moment or two. The lower uterine

segment offers no obstacle to the descent of the head. The only difficulty to be anticipated would occur in case of a woman with fat abdominal walls or with great hyperæsthesia of the uterus. Anæsthesia might be necessary. This method can never supersede internal measurements by palpation, but may be employed in conjunction with them, and it has the additional merit of affording a very accurate idea of the relation of the fetal head to the pelvic inlet.

We will now proceed to define the limitations of the different procedures called for in pelvic narrowing, based upon comparative degrees of deformity expressed in inches at the conjugate of the superior strait.

It is obviously impossible to construct rigid absolute rules for the guidance of the surgeon in cases of this kind. Other factors besides that of pelvic contraction have to be taken into consideration, and herein the personal equation, *i. e.*, the skill and experience of the operator, is of great value in deciding in favor of one procedure or another.

The variety of the deformity, as well as the degree of contraction in both transverse and conjugate diameters, the depth of the symphysis and angle of inclination, the size of the fetal head, the condition of the child, and duration of labor are all factors of such great importance that neither one can be neglected in the estimate of the procedure which it is desirable to adopt to effect delivery. In a society discussion or in a formal essay we can venture to split hairs, and declare that this or that operation is the suitable one in a certain variety of deformity, with contraction not exceeding a certain degree. But at the bedside all this is changed. It is results that we are anxious to obtain, to save both lives if possible; which, considering the means at our command at the present day, we are not to be excused if we fail in securing.

The only hope we have of ever being able to accomplish such results is to study our cases in advance. Since it is

practically impossible for two men to agree regarding the exact length of the true conjugate, how are we to be guided by a difference of a quarter of an inch, as to whether we shall elect forceps, version, craniotomy, symphyseotomy, or the Cæsarean section. These are the most difficult problems that can ever be placed before any man, and only the highest judgment, based on the most thorough examination under the most favorable conditions, can hope for a satisfactory answer to these questions.

*Fourth. Can we define with any degree of certainty the limitations of the different operative procedures by an approximate estimate of the extent of the narrowing?*

Under this head we have as elective operations forceps, version, symphyseotomy, craniotomy, and cœliotomy or Cæsarean section. The answer to the above questions may be stated in five propositions.

1. *Those cases in which the deformity is limited to a shortening of the conjugate at the brim and does not exceed  $3\frac{1}{2}$  inches.* In simple flat pelves contraction of the conjugate to this extent may terminate in normal labor, or forceps or version may be the operations of election. When all the diameters are reduced to the length of the conjugate as in the *justo-minor pelvis*, four inches at the latter point may give rise to considerable delay in delivery and require forceps, though a natural birth of a living child at term is probable. A conjugate of four inches in the *generally contracted* flat pelvis may also cause difficulty in the birth and require forceps or version.

2. *Those cases in which the diminution of the conjugate is reduced from  $3\frac{3}{4}$  to  $3\frac{1}{4}$  inches, though a normal labor is not impossible with a conjugate of  $3\frac{3}{4}$  inches.* Playfair says forceps are applicable in all degrees of contraction down to  $3\frac{1}{4}$  inches conjugate of brim, though version is preferable when contraction is chiefly in the antero-posterior diameter, with abundance of room at the sides of the pelvis for the occiput to occupy after the version. Many obstet-



ricians believe that it is possible to deliver a living child by turning in a pelvis contracted to the extent of  $2\frac{3}{4}$  inches in the conjugate diameter. Playfair inclines to this belief. Barnes maintains that, although an unusually compressible head may be drawn through a pelvis contracted to three inches the chance of the child being born alive under such circumstances must necessarily be small, and that from  $3\frac{1}{4}$  inches to the normal size must be taken as the proper limits of the operation of version.

A *justo-minor* pelvis with a conjugate of  $3\frac{1}{4}$  inches may be terminated by forceps. Version is absolutely contra-indicated in pronounced cases of this variety ( $3\frac{1}{2}$  inches). If such a case is seen in time the induction of premature labor, after viability, is preferable to forceps or version at full term. Should labor have begun, the case may be allowed to progress until Nature has shown her inability to cope with the emergency. Then forceps, or later, symphysiotomy, or if the child be dead craniotomy may be necessary.

3. In all cases, without regard to the kind of deformity, if the birth canal is not obstructed by tumors, cicatrices, or other insurmountable obstacles to delivery, when the conjugate of the inlet is reduced from  $3\frac{1}{4}$  inches (8 cm.) to  $2\frac{5}{8}$  ( $6\frac{4}{8}$  cm.) symphyseotomy seems according to the latest reports to be the operation which offers the best chances to both mother and child. The object of separating the pubic symphysis (pubiotomy or symphyseotomy) is to increase by the artificial separation of this joint the dimensions of the birth canal. Quoting from a recent article by Dr. H. J. Garrigues he says:\* "If the symphysis pubis is cut in a woman lying on her back, with outstretched legs, the ends of the bones separate very little, only about half an inch; but if the joints of the hips and knees are bent, the distance is  $1\frac{1}{4}$  to  $1\frac{3}{4}$  inch, and by pulling on the iliac bones this is easily increased to  $2\frac{1}{4}$  inches, without injury

\* *Medical Record*, May 20, 1893, p. 511.

to the sacro-iliac articulations; but if the separation is carried as far as  $3\frac{1}{2}$  to 4 inches, one or both of these joints are torn open.

"In consequence of the separation of the pubic bones a considerable change takes place in all directions of the pelvis, whereby it is rendered much more spacious in all directions or planes supposed to be laid at right angles through the axis."

As a result of the advantage gained by the increase in the dimensions of the pelvis, by the performance of symphyseotomy, the prospect is that craniotomy on the living child will be banished from obstetrical practice. It certainly will be so in hospital practice, and it should and will be so in private practice if obstetricians make themselves familiar with the *rationale* of the procedure and recognize the advantages to be derived from its adoption.

4. In a contraction of the pelvis less than  $2\frac{3}{4}$  inches ( $2\frac{5}{8}$  inches or  $6\frac{1}{8}$  cm.) and not exceeding  $2\frac{1}{2}$  inches ( $6\frac{1}{8}$  cm.) the operation for the induction of premature labor, soon after the thirtieth week, is the operation which may be considered, and like the operation for the induction of abortion in the highest degree of pelvic contraction, is to be compared and comes into competition with the modern operation of Cæsarean section. Until recently contractions less than  $2\frac{3}{4}$  inches in the *justo-minor* pelvis, and of less than  $2\frac{1}{2}$  inches in the simple flat pelvis, placed these cases under the ban of that sacrificial procedure—abortion. At the present time, the new Cæsarean section, by means of a more perfect technique, asepsis, and the more perfect diagnosis of the conditions demanding operation, offers to the patient a procedure which is greatly to be preferred, in view of its life-saving features to both mother and child. Abortion may be avoided and premature labor is unnecessary. Cæsarean section seems absolutely indicated in any pelvis whose diameters are below  $2\frac{5}{8}$  inches *conjugata vera*, with a living child; also in cancer of the cervix, in oblique

deformities of the pelvis, and when tumors obstruct the vagina so as to render the birth of a living child impossible.

5. Craniotomy, since the revival of the operation of symphyseotomy, has a very much more limited field of applicability than formerly, if recent impressions prove to be reliable.

Upon the dead fetus it is certainly justifiable in moderate degrees of pelvic contraction, in malpresentations and positions, deformities of the fetus, and in cases when the conjugata vera is under  $2\frac{3}{4}$  inches.

Whether craniotomy upon the living fetus is ever justifiable is a question which men of large experience are not agreed upon. There will probably always be cases in which it is the only practicable resource left open to the operator. As for instance in a case of impacted occipito-posterior presentation, or a mento-posterior face presentation when the mother's conditions as indicated by the temperature, pulse, loss of strength from the fruitless and prolonged efforts at delivery, associated with dangerous thinning of the lower uterine segment, is such as to make any operative procedure dangerous except that which enables one to deliver by the speediest and safest means possible, viz., craniotomy.

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## MENSTRUAL PAIN.

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BY

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MRS. P., aged forty-three, slight ; nervo-sanguine temperament ; mother of two children. Personal appearance of no unusual neurotic symptoms ; called on me for relief of headache. She had suffered from a lifelong dysmenorrhea, but had regarded that trouble as incurable and awaited the climacteric for its cessation. The unadorned symptoms

of this case are few and common, but the peculiar features are the long duration and the fact that they were unaffected by the experiences of married life and medication.

Menses appeared at thirteen, uniformly anticipated by three days. The present menstrual conditions are substantially as follows: flow dark at first, then becoming lighter; profuse for three days, twelve napkins being required at the period. At the menstrual epoch, until about five years ago, she experienced sharp, reflex epigastric pains, which increased in severity until overwhelmed by morphine; when a deranged stomach with vomiting ensued, and the advent of headache. The periodical headache had been worse since the subsidence of the epigastric pains some five years ago, and were characterized as a hard, steady, pressing pain over the right eye. The menstrual pains came in paroxysms; cramping, laborlike, and so frequent as to be almost constant, commencing several hours after the flow, and so severe as to necessitate her taking her bed for a day.

Her physician was baffled until morphine was administered; after which a few days were required to recover from the combination of pain and anodyne. Thirty years of such experience might well fasten the conviction that her case was incurable. The patient refused a local examination, which left me only the subjective symptoms on which to base my prescription.

August 1.  $\mathcal{R}$  mag. phos 2x, a powder to be taken in hot water before meals, and three 10-gr. powders of exodyne (a new hypnotic combination of coal-tar derivatives, manufactured at Orange, Mass.), to be taken instead of morphine if the pain was intense; she thinking it impossible to pass through a period without an anodyne.

September 1. The last menses were entered upon with considerable relief, but fearing the usual suffering she took the exodyne powders.  $\mathcal{R}$  continued.

October 1. Has not needed the sedative powders for pain, it being lessened at least one-half, but anticipating a

headache she took one.  $\mathcal{B}$  continued, except the exodyne.

October 20. At this menstrual period, suffered only about two hours of common discomfort, and during it was able to keep at her usual work. Has not had a headache since the first prescription, nor vomiting since the second one. She would consider herself well if she did not regard her case as a very unusual one.  $\mathcal{B}$  mag. phos., morning and night.

November 12. Menses anticipated one week from overwork; had uterine pains for three hours, followed by some headache; took two exodyne powders with quick relief. I then learned that she had eczema at the age of twenty, which was suppressed by a wash, and an occasional slight reappearance in the axillæ since that date.  $\mathcal{B}$  mag. phos., mornings, and sulph. 30, nights.

December 1. Menses occurred in three weeks with very little pain.

January 1. Has only the discomfort of ordinary menstruation; no headache since November 12—dismissed herself as cured.

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## MATERNAL IMPRESSIONS, WITH TWO CASES.

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BY

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WHATEVER may be the individual views of the practitioner on the subject of "Maternal Impressions," it must be conceded by all that their study presents occasional cases of marked interest to the accoucheur.

Ages ago, when superstition held full sway over the minds of mankind, nobody thought of doubting that profound impressions made upon the mind of the pregnant woman

had a marked influence upon the child *in utero*. All sorts of defects in the child at birth had their cause traced to some shock which the mother had experienced. In some cases the defect and its alleged cause have been along the same lines, while in others no apparent points of similarity appear.

At the present time there is a disposition to sift all questions through the finest meshes; nothing receives credit that cannot show some shadow of fact to support it. It is but natural that the time should come when this subject should also be submitted to the crucial test, and be established or refuted upon a pure basis of fact. And this is just what is occurring. Many physicians refuse to accept the idea at all, and are content to laugh it aside as an old-fashioned notion long since exploded. Others are trying conscientiously to solve the problem.

In studying the relationship between maternal impressions and fetal defects we should carefully sift out all cases which are merely "hearsay" evidence, and which are not well vouched for by competent authorities. Where the mother receives a severe shock, early enough in her pregnancy so that the change existing in the child at birth is not incompatible with the stage of fetal development at the time the shock was received; where the mother has dwelled upon the matter at the time, and been distressed by the occurrence; and where the deformity or defect resembles the cause of the fright, I think we are justified in assuming that we have evidence in support of our theory regarding maternal impressions. Leaving out entirely the discussions of the various interesting problems which the subject presents, I desire to record two cases from my own practice, feeling sure that they will be of sufficient interest to claim your time for a few moments.

CASE I. Mrs. S., aged twenty-three, primipara, engaged me in the latter part of June, 1891, to attend her in confinement. She was delivered January 25, 1892, after a

natural labor lasting about six hours. The child was a plump, nine-pounds' boy, well developed in all respects except the lower limbs. But before describing these let me go back and give a little of the history bearing upon the case. The father of the boy had recently purchased the house in which they lived. Its last owner was a Mr. C., whose wife had given birth  $2\frac{1}{2}$  years before to a child whose feet were both in the position of talipes equinovarus.

When Mrs. S. was four months along in her pregnancy this Mrs. C. came into the room where she was, bringing her crippled child, and placed it on the floor, where Mrs. S. watched it hobble about. The poor child made a deep impression upon her, and she often remarked afterward that "she hoped she would not have a child like that." She twice made the remark to me. Before Mr. C. owned the house it was occupied by a family named G. Mrs. G. gave birth to a hydrocephalic child. Before them, a family named H. lived there. Mrs. H. gave birth to a child with single talipes equinovarus. These facts were all known to my patient, and she remarked on the fatality attached to the house.

*Her* child was born with double talipes equinovarus. Here were four children born in this house, within a few years, of different mothers. They were all deformed—three with talipes equinovarus, one with hydrocephalus.

The families are all living in the vicinity now, and so are the children, except the hydrocephalic. I have made careful inquiry, and can vouch for the facts as stated. The parents, in my case, were both healthy, strong, hard-working English people, and there is no history of any deformity on either side of the family.

Their child has proved to be well and strong in every way, and has the usual degree of intelligence for his age. I operated twice upon the feet, and the results bid fair to be good. The tibialis anticus and the posticus tendons

were divided when the child was but ten days old, relieving the varus; the equinus was overcome by severing the tendo-Achillis three months later. The feet are now nearly natural, a thickness at the instep, caused by deformity of the bones of the foot, being the only apparent trouble. Thus I hope one case of maternal impression has been robbed of its evil effects.

CASE II. Mrs. E., aged thirty, gave birth, May 16, 1892, to a seven-pound boy, plump and healthy. It was her fourth child.

In December previous she spilled some hot sugar on her hand, burning her left ring finger severely. In January her husband's father came in with his right hand burned badly with hot oil. His ring finger was the worst, being raised up into a large blister, and inflamed about it. She dressed the hand, and it made her nervous and fidgety for several days.

At birth her boy had on the back of each ring finger and each fourth toe a burn covering nearly the whole dorsal surface. I say "a burn," for such it was to all appearances. The base was red, angry, and inflamed, and it was covered with blisters of varying size. I opened these, and they gave forth a thin, watery fluid. A little calendula cerate and linen bandage were all that was needed to cure them.

At this time, nine months after birth, there was still a reddish discoloration under the skin at the seat of the "burns." I trust that these two cases, which have been extremely interesting to me, will stimulate a study of similar cases by my hearers.

Every physician will find some cases worth recording, if he will endeavor to trace the cause, when a deformed or disfigured child is delivered by his hand. The written history bearing on the subject makes interesting reading. For instance, we read that James I. could not stand the sight of a drawn sword, and his apprehension is attributed to the



fact that his mother, prior to his birth, saw Rizzio cut down in her presence.

Coming nearer home, we learn that the mother of that notorious young outlaw Jessie Pomeroy took delight, while carrying him in her womb, in watching his father pursue his vocation as a butcher. Many other cases have a truly historic interest.

It is true that every shock to the maternal system, when the woman is in a pregnant state, does not produce an abnormal condition in the child. It is equally true that all cases of deformity in newborn children cannot be traced to an "impression" upon the mother's nervous system. But there are cases enough where the relationship is well established to make it imperative that our pregnant patients should, as much as possible, be guarded from severe emotional disturbances, especially when these are of a distressing or painful nature.

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### RIGIDITY OF OS UTERI—A CASE, WITH ITS SURGICAL TREATMENT.

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BY

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ON the morning of November 18, 1892, I was called to attend in her first confinement Mrs. D., who is about twenty-two years of age. Her general health has always been good, although in physical make-up she is slight and seems rather frail. Menstruation has been her chief trial, for it has been almost invariably attended with severe pain and vomiting. She had been married about a year before conception took place.

On reaching the house I ascertained that she had reached the reckoned time for parturition; that the ordinary pains

of the first stage had been present for several hours ; that previous to the beginning of the pains she had been awakened from sleep by a gush of water ; and that the gushes had continued since then with recurring pains, which had soon followed and were growing severer and more frequent.

Examination disclosed almost no dilatation, as it was with difficulty that the tip of the finger could be pushed through the os and against the head, which was presenting. There was no amniotic sac to act as a cushion in front of the head and assist in the dilating process. The presentation being favorable, and the patient's spirits and strength good, I apprehended no difficulty, excepting a slow labor, notwithstanding the absence of the amniotic sac and of dilatation at this time.

Out of the next preceding thirteen cases which I had attended, nine had begun labor by a spontaneous rupture of the membranes before pains were felt. All had gotten through safely without any special complication, forceps being used in but one case. The case I am now relating, the tenth, proved the exception.

During the forenoon the conditions remained about the same, pains of the same character and frequency, patient in no distress. When I called at noon the os was as tightly closed as in the morning, the pains those of the first stage, but harder than before. I directed hot milk and broth to be given in small quantities frequently ; saw that the bladder was emptied ; ordered the bowels cleared by a large hot enema ; and directed a hot vaginal douche to be given every half hour.

It is sufficient to say that at six o'clock the os did not show any further dilatation, notwithstanding that I had given various remedies, internally, hypodermically, and by suppository. Chloroform was judiciously used and the patient given rest, mentally and physically. About this time pains typical of the second stage of labor, regular bearing-down pains, came on. During one of these con-

tractions the head, within the uterus, would be forced down into the pelvis, but the cervix remained as rigid as ever, having dilated only sufficiently to allow one finger to be introduced through the os. With that finger I endeavored to dilate sufficiently to allow of the use of Barnes' dilators. But all the force I could apply had no marked effect. The edge of the os felt like a rigid cord, slightly elastic, but not dilatable. Somewhat prolonged manipulation did not result in sufficient effect to allow of the use of the dilators. The patient now beginning to show distress from the long-continued strain, and other methods failing, I concluded to resort to incision of the cervix. Taking stringent antiseptic precautions, the patient being under the influence of an anæsthetic, I passed a probe-pointed bistoury within the os, using the finger as a guide, and made a number of incisions in the cervix around the tough, cordlike circle of the os. The depth of the incisions was intended to be about a quarter of an inch each. The deepest ones were made at the sides and were less than half an inch. The effect was very satisfactory, for I was enabled right away to carry on dilatation with the fingers, the cervical tissue seeming to be normal after the tough ring was cut through. As the contractions were becoming weak I applied forceps as soon as I could make room for them.

While endeavoring to save the perineum by "making haste slowly" I was informed by Dr. Sylvester, who was etherizing, that the pulse had become very rapid and weak and that there was necessity for haste. I, therefore, quickly delivered the child, a large male, but the perineum and sphincter ani were sacrificed thereby. Immediately following the delivery there was a frightful hemorrhage, more than could be accounted for by rupture of the cervix or perineum. Expelling the placenta by Credé's method, I passed my hand directly into the uterus and found it flaccid and uncontracted. Irritation, with one hand within

the uterus and the other over it on the abdomen, caused it only partially to contract. Hot water, quickly at hand, injected in a continuous stream within the uterus, caused firm contraction, which was lasting. The heat also had a very good effect in stimulating the patient, who in the meantime was receiving brandy hypodermically. Because of her weak condition no attempt was made at reparation of the perineum. Surrounded by hot-water bottles she, however, rallied very nicely.

Convalescence came on without a hitch, and the temperature did not once pass the one-hundred mark. As there had been an unusual amount of manipulation, and there was a large cut and torn surface, there certainly was reason to fear a poor convalescence, complicated with septicæmia. The fact that there was no septicæmia was due to strict antisepsis being carried out from beginning to end of the labor. At no time during the various manipulations by hands and instruments was the necessity of keeping the genital tract in an aseptic state forgotten. It is not the use alone of antiseptics that brings success in operating. It is the manner of their use and an intelligent comprehension by the operator of their purpose.

The ideal condition is that of asepsis. The successful operator is he who, knowing that, knows how to obtain it. It matters not whether it is accomplished by hot water, by chemicals, or by the let alone method, so long as it is understood what will cause sepsis as well as prevent it, and as long as every move is made with a knowledge of its effect, whether for good or evil.

Slovenly, careless, halfway methods are not compensated by an extra large supply of chemicals in aseptic surgery.

Persistent rigidity of the os uteri may become a very serious complication of labor through exhaustion of the patient from protracted suffering; liability of hemorrhage from extensive laceration; subsequent sloughing of tissue

subjected to long-continued pressure; hemorrhage following such sloughing; and septicæmia.

Different cases exhibit varying degrees of rigidity, and undoubtedly most get through without manual aid if they have the help of the elastic cushion of unruptured membranes. They are simply prolonged and trying cases. The exceptionally rigid cases are the dangerous ones, especially when the membranes have ruptured.

There have been reported deaths from hemorrhage following a deep laceration of the cervix, also from hemorrhage occurring during the puerperal period, the result of a deep slough opening the uterine artery. The complete circle of the os uteri has been torn off and expelled during labor. Several such cases are on record. It is in the cases where the membranes have ruptured, allowing the amniotic fluid to escape, that the greatest danger exists; for the hard head pressing against the cervix will in time obstruct the circulation, and sloughing is pretty sure to result unless proper manual aid is given at a seasonable stage.

The treatment of rigid os uteri is determined by the length of time labor has lasted, the patient's strength, mentally and physically, and the presence or absence of the "bag of waters."

As long as the membranes are unruptured, the patient in good condition, the pains strong, and the parturient canal not hot and dry, it is advisable to wait for further efforts of nature. At this time the bowels and bladder should be emptied. The patient should be given hot nourishment in small quantities, frequently, and remedies to allay nervous excitability should be administered. Anæsthesia at this time is frequently followed by relaxation of the os. Hot-water vaginal douches are alone sufficient in some cases.

If the membranes have ruptured, the vagina is hot and dry, the patient growing weak, and no progressive dilata-

tion is apparent, it is not safe to delay longer for nature's efforts. Manual efforts are now demanded.

As all manipulation during labor is attended with danger of septic infection, it is necessary to use antiseptic precautions. In case of operative measures it is mandatory to be doubly careful, as such operations may be made safe or dangerous according as faithful antiseptic accompaniments are used or neglected.

It is my custom in uncomplicated labor to make very few vaginal examinations. In some cases one only has been sufficient. Such examinations as are necessary are made only when I am sure that the patient's external genitals and my own hands have been rendered aseptic by proper measures. I believe that the vagina is in an aseptic condition naturally, and will remain so if germs are not carried in by the operator. It is this belief and practice, I am very positive, that has enabled me to carry most cases through confinement and puerperium without a rise of temperature above the normal after the first twelve to fifteen hours.

Using such antiseptic precautions, in the case of rigid os uteri, dilatation by the fingers may be attempted, the patient usually being anæsthetized. It may be possible to overcome the contracture by this method alone. Or room may be gained for the use of Barnes' dilators and the process continued with them.

Failing in both of these attempts it becomes necessary to incise the rigid ring. This is done by making six or eight short cuts with a probe-pointed bistoury or scissors around the contracted ring of the os, using one or two fingers as a guide. Such incisions will not cause arterial hemorrhage, while a deep rupture from powerful *vis naturæ* is very liable to do so. These multiple incisions usually bring about a state of ready dilatability and do away with threatening dangers.

Further dilatation may be carried on by the "bag of

waters" if it is still unruptured, or by fingers or Barnes' bags; or the labor can be terminated by forceps or version as is determined to be best by the patient's physical condition. The after-treatment must be such as to render the genital tract aseptic to insure a good convalescence.

The subsequent history of Mrs. D.'s case is soon related. In a little over a month from the time of confinement she commenced to menstruate. No pain attended the function; and that made her happy, for menstruation had been her *bête noir*. However, the flowing did not stop at the proper time, and as it was considerable and was making her weak, I curetted the uterus. This was immediately effective. Since then she has menstruated regularly without pain, and the flow is of proper duration.

In March I operated upon the cervix and perineum. In repairing the perineum I used a flap or modified Tait's operation, and the result is proving to be excellent, notwithstanding that the sphincter ani was torn through.

There is now perfect control of the sphincter, and, as far as her own sensations are concerned, there is nothing abnormal about her condition.

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## THE SYPHILITIC MOTHER.

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BY

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MERCURY is not the last word in the treatment of syphilis. If it were this paper would have no excuse for being. And yet so widespread is the idea that mercury is the panacea in this hydra-headed disease that the medical mind turns almost automatically to this drug in the treatment of it. If this were only true in old-school

practice it would not interest those who claim to base their therapeutics on the Hahnemannian law as a practical question. But so tinctured are we with the old ideas of specifics that the homeopathic school, as represented by a majority of its members, still looks to mercury as the one resource.

This was illustrated to me some two or three years ago by a young physician, of more than ordinary ability, when he announced to me the fact of his marriage. He had been syphilized several years before, and in fact had had syphilitic fever, one of the only two cases which I have ever seen, and which was treated as a typhoid, by those who knew no better. I presume the dubious, possibly quizzical, look in my face (for I wondered what would be the proper term to use to express the "love" which he professed for the innocent girl whom he had beguiled into such a marriage) led him to say: "Well, if I see any reason to fear pregnancy I shall put her at once on specific treatment." "And what may that be?" I asked. "Why, mercury, of course."

Now, I do not deny that one of the salts of mercury may be, and often is, homeopathic to such a case. I do deny, most emphatically, that it is good practice to give mercury in any form to a pregnant woman because she is syphilized, or is in danger of being syphilized through her unborn child.

Holding as I do that our duty to the pregnant woman dates from the moment of conception, and that, unless she is that *rara avis*, a perfectly healthy woman, she needs careful oversight through the term of pregnancy and especially during the earlier weeks of gravidity, it has seemed well to me to direct attention to syphilis as affecting the mother and child.

Fortunately, syphilis is no longer the ravaging terror it once was. Nevertheless, it is also true that, in ways obscure and devious, the syphilitic taint is still at the bottom of



many constitutional troubles. But constitutional troubles have queer ways of cropping out on the surface; and no dyscrasia is more protean in its aspects than the syphilitic. I know I am running counter to the belief of many worthy members of this society, and laying myself open to the accusation of taking a very superficial view of the case, when I affirm my practice and belief to be that each of these cases should be treated on its symptomatology, and without any reference to the supposed cause of the trouble. The value of a correct diagnosis is not here in question.

The remarks made by Professor Charles Deady, at a meeting of the New York Pedological Society, about a year ago, that he had seen ocular disease of undoubtedly syphilitic origin cured by sulphur are illustrative. There would seem to be a sort of poetic justice in administering brimstone for that devilish disease, but no one claims that sulphur is an anti-syphilitic. It will cure a syphilitic patient, however, whenever his symptoms present a picture of the sulphur pathogenesis. Only this and nothing more.

What then can we do for the syphilitic mother? If we eliminate from our mind the bias of specific treatment, and study the case simply as a morbid state to be relieved and cured, we will solve the problem correctly. But this is not an easy thing to do, because in midwifery we rarely meet the disease in its active state and the symptoms we can obtain are usually indefinite in outline. For, should the woman conceive and become syphilized at the same moment, the product will be cast off after a few weeks as a shapeless mass. The same will happen if she has recently been syphilized before conception.

The class of cases I have in mind are those descended from syphilitic parents, and who have inherited aberrations from normal health. These are apt to lie latent until the woman becomes pregnant. Then begin various morbid conditions. She has, perhaps, a peculiar fetid leucorrhœa, or persistent headache, or a blotchy condition of the

skin, or wandering, but severe pains, or some other ailment which she has never had before. Of course, it is very easy to ascribe these to the pregnant state, and tell the woman she will be all right when the baby is born. But as a matter of fact she will not be all right, nor the baby either.

The healthy woman is peculiarly hearty and vigorous during the pregnant state. It is physiologically and biologically the natural state of womanhood. If she is not so then the child will suffer from structural weakness, and will not live out half the three-score and ten which is said to be the natural limit of vigorous vitality. If the mother is not healthy during gravidity, the child cannot be. As obstetricians we have a double duty, to mother and child, during the period of gestation.

Now although the symptoms in these cases are often very difficult to collate, a careful anamnesis is profitable. This may lead to giving almost any remedy in the list from A to Z. I have seen apis remove serious lesions in the skin and improve the whole general condition, where the patient was suffering from the effects of syphilization through the fetus. And I have also seen zincum remove peculiar nervous conditions apparently arising from the same cause.

In the treatment of these shadowy cases we are frequently balked by our ignorance of the *materia medica*, and by its imperfections. It is probable that we do not yet know all about so common a remedy as *mercurius solubilis*; what then shall be said of *sarsaparilla*, and *podophyllum*, and *staphisagria*, remedies peculiarly suitable to some cases of syphilis? Unfortunately, therefore, much of our prescribing is merely a sort of guessing, and the recognition of this leads to falling back on mercury and potash as "good enough" treatment.

It would be well for our patients if we could always avoid empirical prescriptions. But I will be frank enough to say

that I have not arrived at that point myself, and hardly expect ever to do so.

Among remedies which I have used upon pregnant syphilized women, I might mention arnica as a remedy containing in its pathogenesis many symptoms found in secondary and tertiary syphilis, and marked improvement follows its use when so indicated. Oleander I have used once for its peculiar backache, with steady amelioration and complete cure.

Carbo vegetabilis is not fully appreciated at its real value in old syphilitics, and I know it has helped me several times in dealing with syphilis grafted on to the pregnant state.

In these cases, of all the salts of mercury I find the most advantage from cinnabaris.

Although empirically used syphillinum is often capable of doing a great deal of good, and when syphilis is suspected, in a case which presents no characteristic aspects, I usually give a few doses of this nosode. Experience with it leads to the expectation either that there will be steady amelioration of the symptoms complained of, or else that it will cause the evolution of symptoms calling for some definite remedy.

Of other remedies, mezerium, corallium rubrum, and stilingia I mention as having served me well; but the whole purpose of this meager outlook at a wide field of therapeutics is to emphasize that which was said years ago by Carroll Dunham, and which will always be true: "Science has no partialities and knows no preferences. Among the servants she puts at our disposal there is no possible position of honor for one above another." Adhering to the spirit of these words we are often led to give, from the symptoms presented, remedies for a pathological state to which they seem to bear no real resemblance.

## THE EMPLOYMENT OF THE FOLDING BED IN CASES OF POST-PARTUM HEMORRHAGE.\*

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BY

J. MARTINE KERSHAW, M. D.,

ST. LOUIS.

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HAVING had some unpleasant experience in the management of cases of uterine hemorrhage, I finally adopted the folding bed as an aid in the management of such cases, from whatever cause the hemorrhage might be. I attend most of my labor cases in the folding bed now, and with a great deal of satisfaction to both doctor and patient.

Hemorrhage following confinement often proves an appalling difficulty. It is an accident that requires immediate treatment, and a treatment too that is sure, because the loss of a few moments, even, may mean the sacrifice of a life. "The thirst, the deathlike pallor of the face, the sighing and gasping, the restless tossing of the arms as of one blindly seeking help, the dilated pupils, and the dim or lost vision of which, with ringing in the ears, the patient may complain; all these make a picture, sometimes sudden in its recognition if not in its apparition, which will at once declare the imminent peril and its cause, and must remain forever fixed in the memory." This difficulty is all the more serious if the hemorrhage is due to uterine atony. Stimulants are usually given, hypodermic injections of sulphuric ether, compression of the abdominal aorta, pouring of cold water on the abdomen; application of ice to the abdomen; introduction of ice to the womb through the vagina; injections of cold water; injections of hot water. Saturating a rag or sponge with vinegar, carrying it up

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\* Read before the Missouri Institute of Homeopathy at Kansas City, April, 1893.

into the womb with the hand, and squeezing it out on the uterine walls, sometimes stops the hemorrhage as if by magic; chloroform and whisky have been applied in the same way. The perchloride of iron as an injection, or applied with a tampon, has been employed. All of these measures have been used with varying success.

I have, of late years, confined my patients in folding beds. I was led to this because a number of my cases had serious *post-partum* hemorrhage. In one case I was obliged to carry my left hand into the womb and keep it there for several hours, in the meantime kneading the womb with my right hand. In all cases that I now have, whenever symptoms of serious hemorrhage become manifest, I proceed to carry out the following:

1. I immediately elevate the foot of the bed.
2. Contract the womb through the abdominal wall.
3. Ergot, in teaspoonful doses.
4. Whisky.

Before leaving the patient after labor, I instruct the nurse and other attendants how, and when, to elevate the foot of the folding bed; and how to contract the womb through the abdominal walls. It is hard, during the great excitement, to elevate the hips of such a patient quickly; while looking for books or bricks to raise the foot of the bed the patient is bleeding to death. The advantage of the folding bed is that it can be operated in a moment; everyone knows how to do it, and why it is to be done.

## SIMPLE UTERINE HYPERTROPHIES AND PASSIVE HEMORRHAGES.

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BY

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WHEN one allows his mind to run over the field of gynecology, and seek for a subject to bring before a society for its consideration and discussion, it seems to me a difficult matter to select that topic which shall be of the most interest and profit. As diagnosis by exclusion is a method which is usually successful in diagnosis, so selection by exclusion is perhaps a safe method.

As I have looked back over the years of my practice, I have allowed myself to exclude those affections which have been ready to yield with little annoyance, and have selected these two as being, perhaps, among the most common and intractable. I have selected them, too, because, although they have been among the most annoying and intractable, it seems to me we are now able to conquer them much more quickly and readily.

In speaking of simple hypertrophies, we exclude hypertrophies due to malignant or non-malignant growths, and refer to the condition described by that almost poetical writer on the diseases of women, T. Gaillard Thomas, as "Areolar Hyperplasia." This is an affection which I believe is due, first, to subinvolution, either after childbirth or miscarriage; second, to carelessness or colds during the menstrual period; third, and this is a theory that I have never heard advanced by anyone except myself, though it may have been many times, yet never come to my attention, namely, the lack of proper care at the close of lactation.

In the first case, namely, subinvolution, a laceration may be the active cause. Of course this may be supplemented

by the many injudicious things that surround the puerperal condition, such as getting up too early, the improperly used douche, or the lack of care for constitutional tendencies. As a natural sequence of an over-large uterus with an increased weight, we may have the numerous displacements, ovarian irritation, irritation of the bladder and rectum, etc. But these are all text-book facts that are open to every studious physician. Given the condition, what shall we do for it? The old method has been to attempt to replace the uterus and hold it in place by tampons saturated with glycerine, elaterium, or some other hydragogue, and later to attempt its support with some form of pessary; in other words, trying to remove the condition by abstracting the serous parts of the blood from the uterus, and then to correct the symptoms of malposition by some form of uterine support. The theory has been right, namely, to remove the cause, and then if necessary to correct the malposition. To my mind, however, the results of this treatment have been anything but satisfactory. The hydragogue effect has relieved the uterine weight and congestion temporarily, but only in very mild cases has it been anything but a temporary relief. That is to say, it has been a palliative and not a corrective treatment, and has necessitated our very frequent attendance upon our patients, and that we should do our work for a very small fee, or that our bills should be long and large, and worst of all that we have not been able to give value received. Moreover, when an attempt has been made, as has been made in many cases, to support the uterus by some mechanical support, while the organ was still heavy from hypertrophy and congestion, I believe it has been not only not beneficial but absolutely injurious, in that, in trying to support this over-heavy uterus, we have induced abrasion and ulceration of the intra-vaginal walls, and have caused such a pressure upon the uterus, by whatever contrivance we have used, as to obstruct and in many instances render the areolar hyper-

plasia greater rather than less. Mark me, I do not say and do not wish to convey the impression that no one has ever had good results from tampons, hydragogues, and pessaries. Many good results have been secured, but they are usually in milder cases.

Further, cases in which the good results may seem to have been obtained may, later, have left your patient in a condition in which the last evil was greater than the first. We find in this condition of hypertrophy, almost invariably, a marked condition of endometritis and a soggy or boggy condition of the intra-uterine mucosa. Upon being touched with the sound it readily bleeds, and in short presents all the well-known conditions of endometritis. Now, if upon examining the case we find a simple hypertrophy with no laceration of the cervix, I believe there is only one treatment open to us which will obtain the best results most certainly, most quickly, and most satisfactorily, and this is to anæsthetize the patient, draw down the uterus with the vulsellum forceps, dilate the uterus thoroughly with graduated dilators, irrigate it thoroughly, curette it thoroughly with a sharp curette that, as often explained by Dr. J. W. Streeter of Chicago, "has never been sharpened," and again irrigate, letting a proper solution of bichloride pass in and out of the uterus until it passes out as clear as it passes in, and then, if necessary, again curette thoroughly until the practiced hand shall feel nothing but normal tissue under the curette. This feel should be much the same as that produced by drawing the curette over the cartilaginous part of the nose or the palm of the hand. We should always measure the uterus with our sound the first thing after introducing the sound, and then, after curetting and irrigating, measure again.

If, as is frequently the case, we find the uterine depth much reduced, we may simply dry the cavity with a strip of ten per cent. iodoform gauze. Be sure always to leave the uterus in proper position, irrigate the vagina thoroughly



with a bichloride solution, dry it with borated gauze, and then pack it loosely with a dry strip of five or ten per cent. iodoform gauze. I suggest the use of borated gauze to dry the vagina simply because, for sponge purposes, it is just as good and much cheaper than iodoform. If, however, upon sounding the uterus and curetting and irrigating we find that the uterus has not decreased in depth as much as we had hoped, then I believe we should pack it moderately full of iodoform gauze or some other antiseptic wicking. This gives the uterus something to contract upon, and supplements, and usually renders successful, the work previously done. Then we should let our patients remain in bed for three, four, or even more days. Insist that they have patience. Never attempt to hurry, and we get good results. If the packing is left in the uterus, it should be removed in from six to twenty-four hours, according to the amount of packing required. After twelve hours the gauze should be removed from the vagina, and for several days a douche given, at least once in twelve hours, of water rendered antiseptic by boracic acid.

Should we find that this is not a simple case, but a case of enlarged cervix, besides being lacerated, we must curette, irrigate, and at the same time operate on the lacerated cervix. I would urge, in operations for lacerated cervix, the necessity of making an incision or cut at the bottom of the laceration, thus making the laceration deeper than it would otherwise seem to be, and then removing the sides to the extremity of the first cut. By doing this we render it possible to secure a plug and also remove a marked V-shaped piece. Then when we bring the edges together for suture, we have removed enough so that we have a cervix of normal size; and when this heals we will find it almost without exception will be followed in the course of two or three months by a gradual decrease in size until it reaches almost or quite a normal size. If the work is properly done, it will rarely be necessary to use any subsequent appliance to remove any

displacements which were due to any abnormal condition which we have corrected.

In some cases where the cervix is enormously enlarged as well as the fundus, and yet no laceration exists, I would recommend the removal of a V-shaped piece from each side of the cervix, bringing it down to its normal size. Let me insist, however, that, in conjunction with these different operations, you invariably try to correct any constitutional deficiency by the use of the properly indicated homeopathic remedies. Let us remember that perhaps these conditions would not so readily obtain were it not for the personal idiosyncrasies of individual patients, which can only be overcome by the use of the properly indicated "similia" remedies.

Passive hemorrhages must be treated of in this paper very briefly; for there is so much to say upon a subject of this kind that, when one once begins to write, a stopping place hardly comes. Without relating a great many cases which I could relate, and in which I have as yet the first failure to record, I will say that in each and every case of annoying passive hemorrhage, be it at middle age or at the climacteric, I use the curette carefully and supplement it with irrigation. I know it will be said that much can be done with homeopathic remedies; and this is true, and this work should be supplemented by them, and yet—after an experience of a great many, I think about one hundred, cases, without a single failure, so far as I know—it seems to me that it is much better to correct this condition at once than it is to dally over weeks and perhaps months of time with nothing but the indicated remedies. Of course, if it is necessary, we may pack the uterus, but I will say that my experience has been that it is better not to do so when the uterine condition shows a proper response to intra-uterine irritation by curetting and irrigating. I expect the first thing that might be said in the discussion of this paper is that it totally ignores the use of electricity. This is not

because I do not believe in it, nor because I have not fitted my office for its use, but because my experience has taught me that a great deal quicker and just as satisfactory results can be obtained by the methods of which I have spoken, with less expense of time and annoyance to myself and my patient. I have had some cases of subinvolution, combined with slight passive hemorrhage, that were benefited by the method herein described and yet showed a slight tendency to relapse. This tendency was removed by the galvanic current. My aim in the treatment of the diseases of women is to urge that we all prepare ourselves as thoroughly as possible and then do radical but very conservative work; and let me emphasize the word conservative, remembering that in these cases, as in the treatment of all chronic cases, we must surround our patients with as nearly a perfect treatment and hygienic atmosphere as possible.

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## WHAT IS GYNECOLOGY?

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BY

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**A**DVANCE in the theories of medical science, as well as in knowledge of the healing art, has led to rapid increase of specialization among physicians. The lines of modern research have so broadened and deepened that we have neither time nor strength to master all the technicalities of the different departments of our profession. We must therefore discriminate between the comparative values of much that is claimed as progress, holding fast to the truths which have been demonstrated and keeping in mind such theories only as appeal to reason and common sense.

Admitting the necessity of the division of labor in a special sense, we find it difficult to define where the dividing line may be drawn. The human body is a unit, made up of different organs with functions varying in each, yet so intimately blended that perverted action or disorganization in one touches all.

Hahnemann, the great teacher, says, "The physician's highest and only duty is to restore health to the sick." To be able to do this he must not only keep abreast of the tide of medical knowledge, but he should enter other realms of thought which bear upon the science of healing. Hygiene, dietetics, and sanitation claim a large share of his attention. Psychology, sociology, and even theology are in the direct line of his study if he would understand many of the ills of humanity. We are learning that there are many causes of disease not material in the ordinary sense of the word.

The three great divisions of the healing art—preventive medicine, therapeutics, and surgery, are in a measure distinct, but modern classifications and specialties have become so numerous that the mind of the laity is befogged. It can no longer judge how far a man who holds a medical degree may be trusted to treat disease of the body save as he studies it and medicates it in sections. It is not uncommon for a person to be under the care of three or four physicians at the same time. We hear one say, "I come to you; doctor, for my menstrual troubles, but I am having my throat attended to by Dr. B., who sprays it three times a week." On general inquiry as to symptoms we learn that the eyes are being cared for by Dr. C., while the family physician is looking after the interests of the liver. In many of these cases the whole train of symptoms is connected, and proper hygiene and the use of the indicated remedy would soon effect a cure.

Here is a question of medical ethics: Who shall be the sacrifice, the confiding patient who is rapidly becoming a

victim to over-specialization in medicine, or the physician whose honest opinion he seeks?

We were asked by a patient recently if she should take her daughter to a specialist in skin diseases because of a slight eruption on her face. The girl is thirteen years old, and mature beyond her years, being as large as the average woman. The menstrual function began to be established a year ago, but the periods are irregular and the flow profuse. The digestive functions are not acting normally, and the child is very easily fatigued. She takes a cold luncheon on her return from school in the afternoon and a full dinner at seven o'clock in the evening at a fashionable boarding house in the large city where she lives. This is not a case for a specialist in skin diseases; it is gynecological now, and requires such remedies as will favor nutrition and the normal development of the sexual functions. It lies largely in the realm of preventive medicine, and the family physician who allows her future to become clouded by invalidism will be derelict in his duty. It is one of a class of cases that, neglected in early youth, a little later in life seek the advice of the gynecologist, possibly becoming one of those unfortunates who finally reach the surgeon as a forlorn hope.

Heart disease and liver affections disturb the normal action of the pelvic functions, as do abdominal and pelvic tumors. Impeded venous circulation may cause symptoms which are referred to the pelvis, but hemorrhages from the intestines or hemorrhoids do not necessarily call for the services of a specialist in rectal diseases.

Our subject is complex, and the manifestations of gynecian diseases manifold, but the etymology of the word rescues it from the narrow meaning we are gradually coming to give it. In its primary significance gynecology relates to reproduction, and lexicographers define it as the science which treats of the physical condition of women and especially of their sexual diseases. It occupies large ground,

including reproduction and all the conditions normal and abnormal which arise from the activity of the sexual functions.

The rapid advance which has been made in abdominal and pelvic surgery has blinded many to the true scope and meaning of the science of gynecology. The various appliances which have been devised under the mistaken belief that most of the diseases of women may be cured by mechanical measures have also been a strong factor in causing the tendency to limit the field within very narrow bounds. The text-books on the subject present such an appalling array of instructions for the use of instruments, devices, as well as concoctions for topical applications, with innumerable directions in the technique of surgery, that one is led to forget prophylaxis and the curative power of medicine.

There is a growing tendency to arbitrary divisions in specialties which we believe should not be too far encouraged. In a discussion before the British Medical Association in 1891 Dr. Singby of the Rotunda Hospital, Dublin, claimed that the teaching of midwifery and gynecology should go together. In speaking of the impossibility of drawing the line between them he said: "A woman presents herself for examination. The first duty of the examiner is to determine the presence or absence of pregnancy. That is obstetrical. But if she happens to be sterile in consequence of endometritis, she should, of course, be treated by a gynecologist. Under his judicious treatment she so far improves as to become pregnant; provided the pregnancy be uterine her case is obstetrical, otherwise gynecological. Even if the ovum is situated in the uterus, her position is still uncertain, for if the conjugate diameter of her pelvic brim be  $2\frac{1}{2}$  inches or less, she should go to the gynecologist, otherwise to the obstetrician. Her pregnancy probably ends in abortion, which does not improve the endometritis, and she acquires the habit of aborting and again

requires the gynecologist. Becoming pregnant again, she goes to term, but has placenta prævia. If this be partial, the obstetrician is in place, but if complete, abdominal section is, according to Mr. Tait, advisable, and so a specialist in this department is called in. But after delivery by the obstetrician she may be attacked by septic peritonitis, when, according to Dr. Savage, the gynecologist is again required. Should her perineum be ruptured, the obstetrician may at once sew it up, but if primary union was not obtained, she is once more passed over to the gynecologist. But such a course would not only be absurd and contrary to the dictates of common sense; it would frequently be fraught with danger."

In the domain of gynecology the great majority of cases have their apparent origin in puerperality. We use the word apparent advisedly. While some may be due to traumatism or infection in the lying-in period, in most cases the causes may be traced further back in the woman's history. We know of a family where grandmother, mother, and daughter each had breech presentations with every child. They were hard-working women, who scrubbed and worked in the fields. During gestation with the last child the physician directed the daughter to refrain from bending over at her work in the field, but to sit while gathering weeds, etc., and to avoid too vigorous muscular movements. The birth was normal. Were these breech presentations due to heredity, peculiarity of pelvic formation, or to occupation? The science of obstetrics includes more than the mechanical delivery of the child at term. There can be no arbitrary division between obstetrics and gynecology. From birth to death the human body with all its various functions is a unit, and specialists remembering this will strive to guard well the sacred responsibility of their office.

The foundation of many of the diseases of women is laid in early girlhood. The causes are manifold, but whatever the determining factor may be in the individual case, the

result is the same—imperfect assimilation and defective nerve force. Some of the most intractable cases to manage have begun at puberty. Flexions may be caused by neglect of stool or by constipation, the mechanical obstruction impeding the circulation in the undeveloped organ and favoring malformation. Displacements we know to be due to mechanical force overpowering the resistance of the supporting structure, whether the force be applied directly or indirectly. It is claimed that anæmia, so common in women, is in many cases brought about by the improper arrangement and distribution of clothing, crowding and displacing the nutritive viscera as well as the pelvic organs. Anæmia, from whatever cause, is a primary factor in much of the pelvic suffering of women. Neuræsthenia, also so common in females, is closely allied to diseases of the sexual organs.

A mother who consulted me recently said: "I cannot bring myself to tell my daughter facts she ought to know for her own protection. I do not know how to get about it." Alas! all physicians know the sorrow and trouble that often follow this omission on the part of parents to do their duty. It is true that the simplest facts of life, and those which most concern the welfare of the woman, have been so shrouded in mystery that it has come about that the mother cannot instruct her own child in the anatomy and physiology of the body lest it be thought to savor of the unclean. This fact has often been sadly illustrated in our experience. Only a few days ago we were called to see a beautiful girl whose mother had married the second time, leaving this child of twelve years to commence the battle of life for herself. Washing and ironing when at service, then the manufactory, where she constantly lifted heavy burdens, she supported herself and helped her grandparents, with whom she found a home, until one day she fell, exhausted and unconscious. At twenty years of age only she is now a confirmed invalid. Pelvic troubles and spinal



irritation render her unable to walk. She has convulsive attacks at the menstrual molimina, and it is doubtful if she will ever recover the normal standard of health. She said, "Until I was taken with this sickness I had never heard that I had a womb, so of course I did not know how to take care of myself."

If we continue to teach by implication or acknowledgment that gynecology means little or nothing more than abdominal section upon the human female under whatever name we couch it, whether laparotomy, ovariectomy, or coeliotomy, with the odd time which is left from these occupations used in sewing up lacerations and in curetting the endometrium, we belittle our position as physicians and specialists, our students leave college incompetent to meet the demands of everyday practice, and our clients are led into mischief and danger.

There is a glamour about the achievements of surgery which is very attractive if we build only for the present, but our medical students are demanding a better knowledge of the science of gynecology than is found in the art of surgery. It is poor preparation for daily practice if the student's knowledge of the diseases of women is limited to what he acquires in the amphitheater of how to remove diseased organs. He needs to know what gynecology is vastly more than inserting a pessary or curetting the endometrium, or even the surgical skill required in amputating the ovaries.

The frequency of grave operations causes us to query, Are physicians careless of the interests of their patients, or are they ignorant? If neither of these, has medicine no power to stay or cure diseases of the female pelvic organs? We know that in a majority of cases where surgical procedures are called for "someone has blundered."

The tendency to use mechanical means applied from without in the treatment of displacements causes many physicians to forget to call into use the inherent force in

the supporting structure itself. This force is vital and acts mechanically, under proper stimulus. The value of muscular movements, when exercised under the laws of mechanics, will in many cases effect a physiological cure.

An interesting case, which illustrates the power of the contractility of muscular tissue, was reported by Dr. Alice Condit to the New Jersey State Medical Society in 1892. The paper shows forth the value of Swedish movements in hernia and uterine displacements. The wife of the native king of Borada, India, had borne one child. During pregnancy she had umbilical hernia. For four years she wore a truss, the pad being enlarged to cover the enlarging aperture, until at the time Dr. C. took the case it was as large as a saucer. The patient could neither stand nor walk without the pad. On its removal a mass the size of a child's head protruded. The abdominal walls were flabby and hung in folds to the pubes. Under faradic electricity given three times a week and Swedish movements complete cure was effected in five months. She could ride, walk, and play tennis with no discomfort. Two years later she gave birth to a child, with no mishap and no return of the hernia.

The professional mind is to-day largely occupied in devising suitable prophylaxis to guard against infection in the lying-in period, but it is only recently that we have heard a plea put forth to guard women against infection, which touches at the root of many ills it is our duty to strive to avert. Dr. Parvin of Philadelphia, in a recent address before the American Gynecological Association, closed with words which do honor to his intelligence and humanity.

Speaking of the many cases of pelvic suppurations which are met only by important operations, he said: "As physicians and philanthropists it is our duty to care for the health of women and to protect them from disease. Knowing countless cases of wives made sterile, their health more or less seriously impaired by the licentiousness of husbands

who regard the Seventh Commandment as obsolete, we cannot ignore what is called the social evil. If we content ourselves, as so many do, with declaring it a necessary evil, and utter no warning, make no effort to arrest the black tide of disease and death, of sorrow, suffering, and crime, we do not meet the grave responsibility of the hour. An eagle stole meat from the altar of the gods, but took with it a coal of fire that utterly consumed her nest and her young. . .

"My own belief is that if fathers were as careful to inculcate lessons of chastity upon their sons as mothers upon their daughters; if that double standard of sexual morality which prevails in society, regarding the licentiousness of the young man as venial while it brands his sister who lapses from virtue as an outcast never to be forgiven, were forever abolished; if the true horrors and perils of prostitution were made known in a proper manner to young men; if the moral forces of good men and women could be combined, guided by the intelligent and zealous devotion of physicians—I am sure that a brighter, better day would dawn."

Every observer in the field of gynecology has at times felt the utter futility of his efforts to stay disease in women while our healthy girls are being sacrificed to this double standard of morality. Dr. Parvin has so forcibly expressed what we would especially emphasize that we take pleasure in quoting his words. Surely the scope of gynecology is not so narrow as some may be led to suppose. There is much to be done and great need of earnest workers. The brilliant achievements of surgery are not to be disparaged. It is true that the surgeon is sometimes the savior of the sick, but one object in presenting this paper is to call attention to the other aspects of the subject. The question, What is gynecology? might perhaps be better answered by stating what it is not, for in no other branch of medical practice is there greater scope for thought, research, and knowledge.

Daily practice brings the gynecologist face to face with many perplexing problems. He is expected to minister to the results of indiscretion, carelessness, ignorance, and sometimes of crime. The causes of disturbances of health are often so complex that it is difficult to trace them; frequently he stands powerless, confronting abuses he cannot correct. It is easy to fall into the fads and fashions of the hour to the detriment of those who seek our aid because of the name we bear. We are reaping the benefits of the grand achievements of the pioneers of homeopathy who have made our school of practice the power it is in the medical world to-day. We urge the necessity of more diligent teaching of homeopathic materia medica, and of a more lively sense of its power over disease. We trust that through no inertia on the part of its exponents homeopathy may appear to be "languishing in the house of its friends."

Prevention and cure should be our aim rather than palliation. The specialist in any department of our art should be a close observer, remembering always the entirety of the whole man and the unity of the different parts. While sectional work is in one sense a necessity of modern progress in medical science, it is true that a large share of general knowledge is required if we would do creditable work and subserve the best interests of our patients.

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## CHRONIC ENDOMETRITIS.

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BY

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THE disease of which we write is a very common one, and being so frequently met with, a few minutes spent in reviewing its causes, progress, and treatment may not be unprofitable, not so much because of any new information

that the writer hopes to impart, but in opening a field for discussion and getting the ripe experience of our members.

Among the many exciting causes of the disease probably acute puerperal metritis is as frequent as any other. The preceding acute disease may have been such as to endanger life, or so slight as to have been unnoticed at the time, and the indisposition attributed to weakness, slow getting up, or a disturbance of the general system consequent upon the breasts taking on their function.

Another cause is subinvolution, which may itself be due to lacerated cervix.

Imperfectly recovered from abortions, at periods of a few months, are very prolific sources of subsequent endometritis. Displacements are often the cause, though they may be the result of them and may complicate the case.

Extension of gonorrhea is a very potent cause, and one that will be referred to in treatment. Briefly, others may be injuries from instruments, coitus, sexual excitement, stem pessaries, surgical operations upon neighboring parts, as rectum, bladder, etc., extension of ovaritis or salpingitis, though these are more apt to be effects. Carelessness, colds, etc., at the menstrual periods may be efficient, as excessive exercise, dancing, etc., at the same time. In addition to all the above the diatheses are supposed to have strong predisposing influences. Thus the strumous, phthisical, anæmic, rheumatic, and those in poor general health from any condition are especially, from the slightest exciting cause, or even without any additional factor in causation, liable to suffer from the complaint.

We will not dwell much on symptoms nor diagnosis. Most prominent symptom of all is the leucorrhœa in varying amount, not only in reality but according as different patients describe it.

In cases of gonorrheal origin, or those that are purely catarrhal and glandular from other non-*puerperal* causes, the discharge is generally mucous in character; but where

the disease has been of puerperal origin, and a fungous condition of the endometrium exists, the discharge is mixed with blood, often rust colored, and most severe hemorrhages are liable.

The cervix is generally swollen, is patulous, and a plug of mucus is apt to occlude it more or less. All this can be felt, as also the roughness of erosions and the swollen glands, and with the speculum may be seen.

Whether the cervix alone be affected, or the corpus as well or alone, will be told by the location of tenderness, as shown by finger and probe, and size and weight of the different parts. Differential diagnosis, excluding growths, will be made at same time. Of the multiform symptoms arising from the effect upon the general health, space does not permit review.

The progress of the disease, unless checked, is steadily toward hypertrophy of the glandular and vascular tissues and growth of connective tissue, with later contraction, constriction, and atrophy, which latter stage is so difficult to treat that it behooves us to do all possible for our patient in the earlier period.

In treatment we will speak of local measures first. A not infrequent case is where a young married woman, after not many months of matrimony, comes complaining of leucorrhœa, which may be tinged with blood, but speculum would show local origin at cervix, different from the flow in corporeal endometritis. Intercourse, she says, is painful. Examination shows tenderness of cervix, tumefaction, and there may be erosion or not. In these comparatively mild cases benefit and arrest of the whole condition have frequently followed having the patient use hot douches, and, without troubling her to come and have applications made, let her use, when in dorsal position, just upon retiring, a small hard rubber syringe, injecting into the vagina 3 ij or 3 iij of glycerine alone or medicated with arnica, belladonna, hamamelis, hydrastis, or other remedy, as seemed best.

Cure has taken place without stopping intercourse; stoppage or great moderation has generally been advised, but from subsequent information do not think that the advice has been very strictly followed.

Where the cervical inflammation is of a more severe grade, weekly or more frequent applications of Churchill tincture of iodine have given good results. The application is made over the whole length of cervical canal by means of a cotton-wrapped probe. Iodine has been a favorite; have sometimes combined it with carbolic acid. In some cases showing very profuse catarrhal secretion have liked argentic nit. gr. xxx to aqua. 3j, or a very slight brushing of the external erosions or granulations or those in a gaping os, with the stick caustic. A tampon is afterward applied, with glycerine or some glycerole. Here, if patient be allowed to use the small syringe at night, treatments by the physician will not need to be as frequent as otherwise. If cervical inflammation do not yield to above, would think curetting necessary. Of course if laceration were present, would consider that necessary to be repaired.

If gonorrheal inflammation were found involving any or all of the vagina and cervix, would apply thoroughly over every portion a solution of mercuric chloride corrosivus 1-4000 or 6000 at intervals of a few days to a week until the complaint appeared arrested. Had the gonorrheal inflammation already extended beyond the os internum, would not have so much hope of arresting it, but in the uterus would trust to measures to be mentioned in general endometritis. In the latter form, if os be not well open, begin by dilating the cervical canal well. Then thorough application of the iodine is liked here, using, as a general rule, the probe wrapped with cotton, and using the same medicaments as for the cervix. Have also used the small intra-uterine syringe, with perforated slender point, and wrapped with cotton which is moistened with the application after syringe is introduced, the liquid being forced

through the perforations into the cotton. It does well and prevents or overcomes the objection that the application may be lost in great measure in passing probe through the cervix. Do not think so well of suppositories or sticks of caustics, astringents, etc., in the uterus as the application by cotton. Where improvement does not result from above measures we think that full curretting is necessary, and would follow it with thorough application of iodine or caustics, and iodoform gauze packing and draining.

With above measures we shall do much toward preventing tubal and ovarian involvement, or may relieve some that has already existed, as far as thorough drainage can help, but yet know that a certain proportion will yield only to laparatomy.

Medication has not been gone into. It would necessitate a general review of materia medica. In all of these cases the patient *in toto* has to be prescribed for, and most remote symptoms are as likely to give us hints for the remedy as those of particular character of discharge, pain, etc., of the local part.

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## THE ADVISABILITY OF REMOVING THE UTERUS, TOGETHER WITH THE APPEND- AGES, WHEN THE LATTER ARE THE SEAT OF DISEASE.

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BY

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**B**EFORE the Medical Congress which met in Chicago last June I mentioned my belief in the advisability of removing the uterus when disease of the appendages made their removal necessary. This not being the subject of the paper I then had the honor of presenting, it was at that



time only touched upon, and in consequence I promised myself the pleasure of more fully discussing the question at a future date.

While my experience has not increased since I wrote that paper, the usual summer vacation precluding much clinical experience, so strongly am I convinced, from the operations I have already performed, of the advisability of this radical operation that I have ventured, without the further lapse of time, to present it now for your consideration.

As we individually and collectively acquire experience in the diagnosis and treatment of diseases of the female reproductive organs, I think we see a smaller proportion of cases that require an operation than formerly. On the other hand, the cases that demand removal of the appendages are more clearly defined and positively admit no other treatment.

Allow me here to say in passing that I am becoming less and less in favor of local treatment for established, or what I consider pathological, conditions of the ovaries and fallopian tubes.

The specialist is rarely consulted until after the initial stages of disease have passed; and when their inflammatory conditions develop the graver lesions, which in nine out of ten cases they will develop if assistance is not rendered promptly, I believe the routine practice of local treatment to be worse than useless. Do not understand me as discarding altogether local treatment; it is the routine use of iodine, carbolic acid, and the glycerine plug of cotton that I condemn. Many cases that ultimately come to an operation are, I believe, directly traceable to the mechanical irritation caused by the treatment itself as well as by the drugs used. In the initial stages of oöphoritis, salpingitis, or any form of pelvic inflammation, local treatment judiciously applied will usually avert the more serious conditions; but when the ovaries or tubes have

become cystic, or adhesions bind them to other organs, the more I see of local treatment the less inclined am I to depend upon it or to resort to it at all. In a few words my position in this matter is: In the initial stages of the diseases under discussion to employ rest and local treatment, but when the case has passed beyond this stage to discard such methods as prejudicial to an operation, which is usually the only means of cure.

It is not necessary to fight over the old battle ground of the propriety of removing diseased uterine appendages. We all know, and we are learning to know better, that there are diseases of the ovaries and tubes that may exist without giving indication of their presence. This, however, does not militate against the knowledge that diseases do exist that can only be cured by removal of the involved organs; such diseases are not only a constant menace to health, but frequently to life as well. All the sentimental nonsense of unsexing the woman we will discard, as in the first place unproven, and in the second place unworthy of a moment's consideration by either the scientist or the layman.

We presuppose a careful diagnosis and conscientious opinion that the appendages must be removed if health is to be restored. In such cases I believe the results will be better and more quickly attained if the uterus is included in the amputation. Both theory and practice force this conclusion.

First, as to theory:

Anatomically the uterus is held *in situ* by the normal position of all the pelvic and abdominal organs, but as within the gamut of health there is considerable and constant motion of these organs, we must look upon the more fixed of them as the ones especially concerned in maintaining the normal degree of uterine ante flexion, viz., the broad ligaments and vagina. Relaxation of the broad ligaments, especially of their upper border, upon which the fallopian tube lies, is almost always accompanied by dis-

placement of the uterus; such relaxation must follow in a marked degree removal of the ovaries and tubes, for in making the pedicle the principal supporting part of the broad ligaments is taken away, hence the uterus is left to move in any direction, supported only by the ever changing vaginal tube and the pelvic position of the broad ligament. This requires no stronger demonstration than is gained from an intra-abdominal examination after removing both appendages. I have generally found the uterus, whatever its position may have been before the operation, to sink immediately into the pelvis and to become strongly retroverted.

To this fact, together with one connected with exercising the ovarian nerve, which I will mention later, I attribute many of the failures we are obliged to record after removing diseased ovaries and fallopian tubes. The uterus becomes a foreign body without use or function. It does not atrophy, contrary to the usually accepted belief; for by ligating the ovarian arteries, the principal arteries of the pedicles, the blood supply of the fundus only is cut off; the large uterine arteries remain untouched, and its branches, as they ramify over the uterus, quickly establish circulation through the temporarily closed ovarian arteries, and the organ scarcely receives any interruption in its blood supply. I have examined many women years after their appendages were removed. As a result I believe the return to an infantile uterus dependent upon the operation to be unfounded in fact and without foundation in practice.

One other source of failure to obtain relief of suffering after removing the appendages lies in the fact that the pedicle is frequently not made long enough to include the ovarian nerve. The principal branch should be completely excised, and thus cut off all communication with diseased, or even deranged, pelvic organs.

But this, perhaps, is more a matter of technique than of theory.

Second, as to practice :

The operation of removing the appendages — that is, both ovaries and fallopian tubes, and I think we must award Mr. Lawson Tait the honor of priority in suggesting this operation—was theoretically and practically believed to offer a certain method of relief from the hitherto obscure and incurable pelvic sufferings that are now known to depend upon diseases of those organs. The operation, however, as originally performed, has not stood the test of time. We are now sufficiently removed from the glamour of its brilliancy to view the procedure dispassionately, and we are able to gather statistics bearing directly upon the percentage of cures effected. It must be confessed that these statistics are not encouraging, and that but for the fact that every other method of cure has been resorted to before this more radical one, and the firm conviction that the basis of the operation—to remove pathological organs—is a true one, a surgeon would scarcely feel justified in subjecting patients to even the present minimum risk and mutilation. A proportion of the cases operated on are benefited or cured, but a large proportion are either not improved or are made worse. In the present condition of the operation we can promise nothing more than that the patient will almost certainly live. This she would more probably continue to do without the operation. A cure we cannot promise.

As I have elsewhere said, the operation is based upon a correct surgical principle—that of removing diseased organs that cannot otherwise be cured, but the original operation is too conservative ; it does not include enough. It removes diseased organs, but leaves others that in consequence become the source of suffering scarcely to be distinguished, at least in severity, from the primary malady. The organ thus left is the uterus, and I therefore hold that we cannot regard the operation of removing the diseased appendages a complete one unless we include the child-bearing organ

in the amputation ; nor can we consider the technique perfect until we make this one of its steps.

I hold that the mortality in operative surgery, if we exclude the manipulation of organs essential to life, is at present a question of technique. By this I do not mean simply certain fixed rules of procedure—such would reduce surgery to the domain of mechanics—but I would include that indefinable natural quality which distinguishes the surgeon from the mechanic, which enables him to apparently set at defiance mechanical laws, and thus frequently be able to justify the digression.

In continuation, therefore, of the opinion already expressed concerning the advisability of removing the uterus with the appendages, the question to be answered is, How shall this be done? My confidence and success in vaginal hysterectomy, and the fact that I have by this method several times amputated the uterus for persistent pain, after the appendages had been removed, led me at first to perform at one sitting a double operation, abdominal and vaginal ; but subsequent experience has proven this to be an unnecessary complication. I now make the entire manipulation through the abdomen, the detail of which does not differ essentially from that which I follow in abdominal hysterectomy for uterine fibroids, though it must be acknowledged to be attended with greater difficulties. The ovarian arteries are ligated with double ligatures, first the left side, then the right, and the structures between these severed. The broad ligament on the left side is then torn or cut with blunt scissors down to the uterine artery ; this is then tied and the cervix severed from the vagina before and behind until the right uterine artery is reached. When this is ligated and cut, the uterus and appendages can be lifted out of the pelvis. If the broad ligaments retract on the pelvis, they had better be brought together with fine catgut continuous sutures. Subsequent experience may lead me to discard drainage, but in

the five cases thus far operated on I have drained through the vagina.

The most difficult step of the operation is the ligation of the uterine arteries, but if the abdominal incision is a long one—and it must be remembered that the length of incision does not affect the mortality, and a long cut is to be preferred to the necessary mutilation of too short an incision—and the heavy curved needles I have made for the purpose are used, I find the manipulation easier to accomplish, and of greater rapidity.

Of course the operation I propose at the best presents greater difficulties, and calls for a higher degree of manipulative skill, than the removal of the appendages only, and should not be undertaken by the novice in operative surgery; but, as I have elsewhere said, I believe we owe it to our patients, and they have a right to demand at our hands that we should offer them the means of perfect cure, and a method of treatment in harmony with the advances made in other departments of surgery.

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## THE USE AND ABUSE OF VAGINAL INJECTIONS.

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BY

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THE truth that "the abuse of any measure is in proportion to its value" is often verified in medicine. The more valuable an agent the more frequently and extensively it is employed. This frequent usage tends to indiscriminate, and the indiscriminate use of any therapeutic agent leads to its abuse. It is probable that with the

intention of cleanliness vaginal injection of water, both hot and cold, was a common practice among women long before they were employed by physicians in the treatment of disease.

No doubt it was this custom which made the profession careless in giving full and explicit directions as to when and how they should be taken. The practice has grown with the years, until to-day their general and indiscriminate use by both the laity and physicians is to be deplored. With the former they are a "cure all" for any "female weakness"; and prescribed by the latter in a routine sort of way, highly unscientific, they are used without desired effects and do untold harm.

We have two classes of vaginal injections: 1. Simple douches of water. 2. Those for topical medication. We wish to make it emphatic that no person should ever use either class of these injections except when prescribed by a physician for some recognized disease. This is the only rule.

Vaginal douches of hot water occupy an important and useful place in gynecology. The constringing of the capillaries by hot water, as shown in the blanched, shriveled appearance of the hand after a long immersion, makes it valuable in the reduction of inflammation; hence we find hot vaginal douches indicated in all pelvic congestions, both acute and chronic, in the prevention and softening of infiltrations, adhesions, and indurations.

To get the full benefit of the hot douche we must produce upon the pelvic textures an effect analogous to that witnessed in the shriveled hand. It is evident to do this we must keep the parts laved a long time in the hot liquid. For this end three things are essential:

1. The douche must not be given hurriedly, but should occupy at least thirty minutes.
2. The water should be hot, at an average temperature of 110°. It may be necessary to begin at blood heat and

gradually increase the temperature; even 115° can be borne.

### 3. Posture.

The position of the patient should be such that the douche will most readily act upon the diseased part. This is always a lying, never a sitting posture. No fact is more patent than that fluids will invariably seek the lowest part of a receptacle. The law of hypostasis, illustrated in every thing around us, holds equally true within our bodies. If the cervical textures are to be acted upon, put the patient in a dorsal position with elevated hips. The Sims position is most favorable to reach the left ovary and surrounding tissues. If the diseased part is on the right, let that be the side the patient lies on.

It is needless to add that with more attention to details and a clearer defined idea of what is to be accomplished by the douche for this particular patient we should hear less often in that discouraged, helpless tone: "Doctor, I have used injections for a long time without any benefit." The facts are that the woman, in a sitting posture, has hurriedly thrown a few spoonfuls of warm water into the vagina and in five minutes has gone about her duties without any relief from her pain and sufferings, and never a thought but that she had faithfully fulfilled the prescribed task.

A word as to syringes. Dr. Emmet was the first to assert that a vaginal douche cannot be properly taken unless given by an assistant with a Davidson syringe. With all respect to the learned authority, we yet believe beneficial results can be secured from a fountain syringe, and that without any harm to the patient. The syringe should be hung only high enough for a slow stream of water to flow without force. Care should be taken that the nozzle of a syringe be made of vulcanite, and not of metal, which collects the heat in using hot water.

A continuous flow of water into the vagina for half an hour, or even a few moments, in any posture, dilates it to



a greater or less extent; in consequence the walls are shortened and we have a slight descent of the uterus; this repeated day after day, even for months at a time, coupled with the enervating effect of hot and warm water on the healthy tissues of the vaginal walls, results in the first degree of prolapsus.

To overcome this tendency to prolapsus after every vaginal douche the woman should take the genu-pectoral posture for a few moments; then lie prone for at least half an hour before she gets upon her feet. The observance of this postural practice will do much toward the recuperation of the tissues.

It is obvious that the best time for vaginal irrigation is on retiring for the night. The pernicious habit of most women to take vaginal douches of warm and cold water for any slight mucous discharge, after each menstrual nixus, and for every pelvic ache and pain, or its habitual use for the false notion of cleanliness, not only injures the constitutions of girls and women, but is the source of much leucorrhœa, prolapsus, suppressed menstruation, and other ills, and must be counted an abuse. In our opinion there is no condition that ever calls for a *cold* vaginal douche.

The use of the douche for cleansing purposes is limited to those cases of acrid discharges and profuse leucorrhœa, and should be taken with the same caution, with this exception—the water need not be as hot.

The second class of vaginal injections consists of medicated water, glyceroles, and other emollients. More careful consideration by physicians is given in prescribing these, and the necessary details do not differ from Class I.

**¶** The great abuse of this class in its use by the laity to prevent conception we pass by without comment; the consequent disease is met daily in practice.

For the attainment of satisfactory results from vaginal injections we urge better discrimination in their use, more explicit directions, and when prescribed that the patient

is intelligent as to time, quantity, temperature, posture, and other essentials. As physicians and specialists for the benefit of suffering womanhood we need to give more attention to common practicalities, lest we become easily satisfied with incomplete success.

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### HYSTERO-NEUROSES.

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BY

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THE importance of this condition, of which the genito-reflex neuroses are only a part, has never been studied as a whole; in fact until recent date but little has been written on this important subject. The impressionable nervous system of woman is the most susceptible of all organs, and responds as readily to peripheral irritation as does the electric bell to pressure upon a distant button. So intimate is the relation existing between the nervous system, the reproductive organs, and the circulatory system that we need to be familiar with their anatomy and physiology to understand the various neuroses. By reason of direct connection of the ganglionic fibers with the vaso-motor nerves, they readily respond to changes, morbid or physiological, which may take place in the vital centers, and no system gives evidence of these reflex impressions more rapidly or more vividly than the circulatory. As the steam valve promptly controls the workings of the engine, so the female reproductive organs, during the entire period of their activity, are the principle governing centers of functional life in woman. As life and health and proper functional activity depend on a normal capillary circulation, and this in turn is controlled so readily by the nerves supplying the female generative organs, and I will

add the rectum also, any pathological condition of these organs by irritation of the terminal fibers of the sympathetic may set up reflex disturbance in distant parts of the body, so severe as to threaten the life of the patient, and so misleading in its symptomatic manifestation as to effectually blind the eyes of the physician as to the cause and proper mode of treatment.

The differential diagnosis between a pathological condition and reflex neuroses, although it may seem to be a very easy matter, is sometimes exceedingly difficult. The manifestation of neuroses is sometimes all out of proportion to the pathological condition; but, with all the difficulties present, in certain cases we may with patience and proper study find the source of irritation. Then and not till then are we ready to prescribe intelligently for our patient. The case may be one requiring homeopathic remedies only, or it may be necessary to combine with them surgical means, or the use of drugs for physiological or chemical effect, or the application of electricity or massage; or it may be a case requiring palliatives only. In any case the physician will be abundantly rewarded for the time and study spent in arriving at a correct diagnosis, and in nine cases out of ten will be able to cure the sufferer, who has been the rounds in search of relief and found none.

The reason so many women remain invalids is because we have paid so little attention to these reflex phenomena, prescribing according to symptoms for a diseased head, throat, lungs, heart, or stomach when these organs were not diseased at all; the trouble being in a pathological condition of some or all of the pelvic viscera, constantly irritating the terminal fibers of the sympathetic, which in turn communicated with the cerebro-spinal nerves, giving rise to the reflex symptoms present.

I will give two cases of hystero-neurosis that came under my care after prolonged treatment with only temporary relief. They illustrate how disproportionate the reflex

symptoms may be to the exciting cause. January 21, 1892, I was called in haste to see a lady whom the messenger stated was suffering with "lung and heart disease," and was then having "a bad spell." I had never before been called by this family and knew nothing about the case, but hastily obeyed the summons. Found a young woman, much emaciated, with staring eyes, violent palpitation, and very difficult respiration. Complained that her head seemed as if it would burst. Gave glon. 3x, which relieved the turbulence of the heart, and then proceeded to examine the case. My patient had been sick three years, almost constantly under the care of physicians of good repute, still going from bad to worse, until at that time she could not lie down on account of aggravation of all her symptoms: difficult breathing, palpitation, pressure in the head, ringing and roaring in the ears, and an annoying cough, with but little expectoration, however; there was no appetite, and what nourishment was taken distressed her stomach; obstinate constipation, and insomnia as persistent as the other symptoms enumerated. Physical examination failed to reveal any organic disease of heart or lungs. There seemed to be no trouble with the pelvic organs. Prescribed the indicated remedy according to totality of symptoms with temporary relief. Studied my Concordance Repertory and Materia Medica, but the remedies would only palliate. After a faithful trial extending over a period of six months I concluded that I was not using the indicated remedy; that there must be a source of irritation I had overlooked, and immediately set about to find it. Upon further inquiry I found her to be twenty-seven years old, had been married and borne three children, but on account of domestic trouble had been divorced and returned to her father's home. Examination of the generative organs did not clear up the diagnosis. Uterus slightly enlarged; few granulations found on the endometrium, showing mild case of granular endometritis; no evidence of cervical laceration

was detected; no hypersensitiveness of the parts; uterus but slightly retroflexed. Rectum was next examined. Found four small hemorrhoidal tumors, but patient said they had never given her any trouble. Advised local treatment of uterus for endometritis, which was given, also replaced the organ, but no improvement followed. During the treatment I discovered some cicatricial tissue near the internal os, and although it was a very small amount—in fact all of the lesions present did not seem to be enough to produce such disturbance throughout the entire organism—I advised an operation.

Consent was given, and on July 18, assisted by Drs. A. E. and V. C. A. Gesler, chloroform was administered, the cervix dilated, the uterus curetted and cleansed with an antiseptic. The plug of cicatricial tissue was then carefully dissected out and the cervix repaired. The rectum next received attention, the small hemorrhoids being removed and the rectum thoroughly dilated. A bandage was then applied with iodoform gauze as a dressing, and patient put to bed. When she came out from under the influence of the chloroform she had lost the tumultuous heart's action with its train of head symptoms. The bronchial irritation gradually disappeared, until she had no cough or symptoms of her former "consumption." The recovery was uninterrupted, and in two weeks she was able to be about the house, without any of her former symptoms except the cough, which, as first stated, left more gradually, but all disappeared in a fortnight more. Sleep was sweet and refreshing, and the stomach no longer made protest against nourishment (but rather craved it), which was taken in liberal quantities, with the results that usually follow proper nutrition in a healthy body. The menses came on at the regular time without pain, and continued only three days. Bowels were regular without medicine. This case took but two prescriptions after the recovery from the operation, and to this date, now over a year, remains well and able to do housework.

Case II. Mrs. M. age fifty, mother of three children, eldest twenty-three, youngest seventeen. Had been troubled with what she called twisting, grabbing pains in stomach since the birth of the first child; also been compelled to wear an abdominal support since that time. Nine years ago a feeling of weight, bearing down and painful sensitiveness of the generative organs, together with profuse leucorrhœa, led her to consult a specialist in Grand Rapids, who treated her for "ulceration of the mouth of the womb." This gave her much relief. He also informed her that she was passing through the menopause, and would not be very well until that period was passed. Patient first consulted me March 23, 1889, with regard to her stomach trouble, the same twisting affecting the muscles of the chest and extremities at times. Menses were regular, and, except a profuse leucorrhœa, did not complain of any disturbance in the pelvic organs. After prescribing for her several times without any decided relief an examination of the generative organs was advised. The examination revealed a bilateral laceration of the cervix, with everted lips, and an areolar hyperplasia. Uterus was four inches deep, soft and flabby; passage of sound or application of the vulsellum forceps caused profuse discharge of dark venous blood. Treatment was at once instituted. Iodized phenol was applied to the endometrium once a week; every second day a glycerine tampon was placed in the vagina well up against the cervix, and held in place by other tampons, thus securing some pressure. Patient was instructed to remove the tampons in thirty-six hours, and use, just before retiring, an injection of about four quarts of hot water. Improvement began at once and continued until the patient was so much better that I did not consider it necessary to repair the laceration. It is unnecessary to say that with the improved pathological condition of the uterus the reflex symptoms grew correspondingly less. They did not leave entirely, however,

but with the indicated remedy and the use of electricity at various intervals the patient was quite comfortable until November, 1891, when she had an attack of la grippe. During this sickness she began to have laryngismus stridulus, the spasms being so severe as to threaten life. Recovery from la grippe was not followed by improvement of the throat trouble. She was unable to leave the house from that time until settled warm weather; the slightest draught or change in temperature in her room was sufficient to bring on laryngeal spasms. With the summer weather improvement came, and continued until October, when the cool weather brought back her old throat difficulty with increased intensity. She was unable to leave the house and soon was confined to one room as closely as the prisoner behind iron bars, it being necessary to keep an even temperature of 85°F. during the twenty-four hours. I advised an operation to repair the lacerated cervix and remove the hemorrhoids, but consent was not given till December. In the meantime remedies that seemed indicated did but little good. Patient gradually grew worse till December 15, when she consented to an operation. Chloroform was administered. The uterus at this time was again large, flabby, and very hyperæmic; it was thoroughly curetted, dilatation being unnecessary, and the laceration repaired. The rectum next received our attention, the hemorrhoids being all removed by the clamp operation. She soon rallied from the influence of the chloroform and made an uninterrupted recovery. Is now passing through the menopause with but very little disturbance. The temperature of the room was at once reduced to 70°, and pure air admitted to the apartment through an open window. No spasm followed. As soon as sufficient strength was regained a sleigh ride was enjoyed, followed by others as the spasms failed to return. Several times after the operation sudden changes in the temperature were followed by disagreeable choking sensations, and the

patient feared a return of the old difficulty ; but they never went farther than disagreeableness, and gradually grew less and less. The appetite, digestion, and sleep became excellent, bowels regular, and the menses failed for the first time to appear at the regular monthly period. At the end of six weeks, however, they came on, continuing the usual time, but did not again appear for three months. Whether the menopause will be rapidly terminated cannot be stated at this time.

A word in regard to the rectal work in these cases. Pathology in the rectum is of equal importance as a cause of reflex disturbance as pathology in the female reproductive organs. Both are supplied by the same nerve, and in either case it is the irritation or pinching of the terminal fibers of the sympathetic that excites and perpetuates the various neuroses. This being the case, it is just as essential that woman have a healthy rectum as a healthy uterus or ovaries. And any treatment that does not remove all irritation is only partial and the cure not complete.

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## ON THE BANDAGE IN CONFINEMENT.

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BY

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A FEW sentences on the subject of bandaging the parturient. This time-honored custom, like all ancient habits and customs, is not to be put aside easily. There are at least two opinions among medical men on this subject: a large and influential section of the profession are strongly in favor of the bandage, while a small minority are in favor of doing away with it. A large majority of our female parturients are in favor of its use; they declare that they



feel more comfortable after the bandage is put on tightly, and doubtless hope that their former figure will still be maintained notwithstanding the disfigurement produced by pregnancy, which, from an æsthetic point of view, is anything but agreeable to the female mind. When we examine the rationale of this ancient custom, anatomically, physiologically, and mechanically, we are forced to the conclusion that it is entirely superfluous, and often positively injurious to the patient. Pregnancy and parturition are perfectly normal conditions of the female, for which nature has made ample provision, except in abnormal conditions, and should not therefore be interfered with so long as her natural forces are equal to the emergency.

The gradual enlargement of the womb, the distention of the abdominal wall, attended by thinning of the muscular fibers, in order that the womb may have sufficient space for its development, however uncomfortable it at times may be, is a normal condition and usually requires no interference whatever. What are the reasons, then, for the use of the bandage after birth? Professor Charpentier of Paris, who may be taken as one of the chief advocates of the bandage, says: "Nothing adds so much to the comfort of the puerpera as a neatly applied and gently compressing abdominal binder." No wonder, when we remember that for months the abdomen has been distended, that the patient feels the need of a certain amount of compressive force. Now notice his caution in its use: "Undue compression is of course to be avoided, else the tendency will be to force the uterus back toward the sacrum, placing the suspensory ligaments of the organ under great strain, and making it likely the patient will, at the end of convalescence, have a retroversion." An additional reason is urged—that with the use of a pad under the bandage it prevents hemorrhage by securing contraction of the womb. My own experience has taught me that the above reasons are fallacious—not only so, but, as I have already said, positively

injurious, for the following reasons: Normally, the womb, a few minutes after its contents are expelled, rises toward the abdominal wall with the os pointing in the direction of the axis of the pelvis, thus occupying the most favorable position for drainage and the first stage of involution; if pressure be made on the fundus by pad, or even by bandage without the pad, the fundus is forced down into the hollow of the sacrum, while the os must look in the direction of the os pubis, thus not only preventing natural drainage by being tilted in that direction, but clearly favoring permanent retroversion, one of the most unfortunate conditions which the parturient could be called on to endure. Preventing hemorrhage by the pad and bandage is also questionable; it is very difficult to arrange either so as to make sufficient compression on the womb to secure efficient contraction to arrest hemorrhage; besides, the conditions likely to produce hemorrhage should be attended to previous to putting on the bandage, as both interfere materially with the proper manipulations necessary to arrest the hemorrhage, should this occur after putting it on.

If the uterus is properly emptied of its contents and carefully watched until the normal contractions occur, in normal labor there is no danger of hemorrhage, and hence the bandage and pad are superfluous.

A still more serious objection to the bandage is compression of the abdominal circulation; the previously distended wall with its minute capillary circulation is crumpled by compression into a comparatively small space, thus placing the blood vessels in a tortuous condition, preventing the venous blood returning to the heart, and thus favoring congestion and inflammation, which are liable to occur under these circumstances.

The so-called comfort said to be derived by some mothers from the bandage is in my opinion more sentimental than real. I have had several cases of late where I have omitted the bandage, and without exception they preferred being

without it ; they experience a much greater feeling of freedom to move in bed, and increased sensation of comfort in every way, make a better recovery, have less trouble with the bowels and bladder, and have no desire ever again to use the binder.

I have said that time-honored habits and customs are not to be laid aside easily ; and here I would utter a word of caution, especially to young medical men : I was some twenty years ago called to attend a young primipara and omitted the bandage ; it was a case of normal labor, and requiring but little attention. I was called out of the city for a day or two, and in my absence some trifling difficulty arose. An allopathic physician was called in, and finding that the bandage was omitted, at once gave the patient to understand that the whole difficulty was due to omitting the bandage, and thus in his *wisdom* and *charity* left the impression that I did not understand my profession. The family evidently took this view of the case, as I was never afterward employed by them. We must therefore be as "wise as foxes" if not as "harmless as doves." In any case it is desirable to explain the omittance to the patient, and in most cases her consent can readily be obtained.

In some cases of multipara with pendulous abdomen, caused by the number of pregnancies, a properly adjusted bandage with elastic sides may be of use in retaining the uterus in its normal position, which the weakened muscles have failed to do ; the same may be said of the bandage, after the patient is up and going about, in those women who are possessed of a superabundance of adipose tissue and are deficient in muscular fiber, who may be pardoned if they thus seek to improve their figure, and perhaps add somewhat to their comfort.

I am thus opposed to the use of the bandage since it is a violation of physiological as well as anatomical laws. By its mechanical pressure it produces displacement of the womb, and in place of adding to the comfort of the mother

it too frequently contributes to disease and death, and should therefore be abandoned.

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## PLASTIC SURGERY OF THE VAGINA.\*

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BY

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**D**R. RUNNELS: Believing that we all agree about the anatomy of the vagina and floor of the pelvis, I need not discuss the part of Dr. Green's excellent paper relating to that subject. Nor have I the time to review the different kinds of lesions of the vagina and perineum. The character and extent of these lesions are not overstated in the paper. I have seen the different kinds mentioned, and have had much to do with their repair. The discussion is limited to three plastic operations, viz.: removal of scars, cystocele, and perineal injuries. The statement is made that "it is bad surgery to leave any wound of the vagina and perineum, whether it occurs during parturition or from other causes, to heal by granulation; that it is the imperative duty of the accoucheur to make a critical examination of the genitalia after every labor, and if he finds any rupture it should be repaired before he leaves his patient."

I grant that a thorough examination of the patient's genital organs should be made immediately after each labor, but I do not believe that a surgical operation must necessarily follow labor immediately in a case of laceration of the cervix, vagina, or perineum, one or all. In the majority

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\* A discussion of a paper read by Dr. W. E. Green, at the World's Congress.

of cases I hold that it is bad surgery to operate on distended and ecchymosed tissues which must undergo physiological involution; that in a case of extensive laceration of the perineum the soft parts have been traumatized and predisposed to infection which a surgical operation does not hinder, but rather invites; that the superficial and not the deep structures of the perineal body are united by immediate perineorrhaphy, provided that union of the parts takes place at all; and that, as a rule, the delayed operation in a case of laceration of the cervix or perineum requiring surgical interference affords the best results.

I have examined a good many women, from one month to several years after they had undergone the immediate operation, by different obstetricians, for laceration of the perineum extending down to or through the sphincter ani muscle, and I must acknowledge that I have not met with a perfectly restored perineum in the entire number. I am convinced that the obstetrician who invariably resorts to immediate perineorrhaphy not only deceives himself, but misleads his patient into the belief that she has a good perineal body.

Let nature and good treatment do what they may toward restoring tears of the vagina and perineum, and wait until after the eighth week from labor to make a thorough operation on the lacerated part under aseptic and favorable conditions. Removal of scars at that time will be a trivial matter in comparison to the long list of evils following the delusion of a restored perineal body by immediate perineorrhaphy.

Deep ruptures of the cervix with complicating metritis accompany ruptures of the perineum as a usual thing, and under these circumstances the vagina remains in a state of subinvolution, and cystocele and uterine prolapse are frequently observed. The anterior vaginal wall is more easily displaced than the posterior. In multiparæ a small cystocele is often seen, especially when the bladder is full. It

is not a pathological phenomenon, but is due to the subinvolved and thickened vaginal wall. When the perineum is deficient in tone a vesical hernia is liable to occur, as the posterior wall of the bladder is adherent to the anterior wall of the vagina and is carried down with it. The posterior wall of the vagina is only loosely connected to the intestinal wall, and therefore rectocele occurs less frequently than cystocele. The uterus is soon affected by the constant dragging of a prolapsed vagina upon its attachments, and thus occurs uterine prolapse and hypertrophic elongation of the cervix. I commend the operation for cystocele which Dr. Green has described.

Stolz makes a somewhat different suture in anterior colporrhaphy. "After freshening an oval surface to correspond with the cystocele, two curved needles are threaded on a silk suture, one needle at each end, and beginning near the cervix, the suture is passed in and out of the whole circumference of the wound about half an inch from the edge, something like the draw-strings of a tobacco pouch. The denuded surface is pushed inward toward the bladder, and the ends of the silk closely drawn and tied."

However, I prefer the continuous suture in layers. I agree with Dr. Green that operations about the cervix or vagina should be performed with the knife or the scissors, and not with either the *écraseur* or galvano-cautery, and that denuded surfaces should be covered with mucous membrane. I approve of Dr. Green's method of operating for incomplete laceration of the perineum. I would advise that the rectum be first tamponed with cotton, sponge, or iodoform gauze covered with vaseline and furnished with a thread; the posterior vaginal wall is pushed forward by the tampon and displayed to a better advantage.

This operation for incomplete laceration of the perineum is a modification of Tait's method, which is much employed. Martin recommends juniper catgut and a continuous suture

on superposed planes instead of silver sutures at separate points. The removal with the scissors of "a pear-shaped piece" from the flaps, as recommended by Dr. Green, takes out the slack and cicatricial tissue from the mucous membrane, and prevents a puckered and pocketed vaginal lining in the completed operation. In this respect the operation is similar to Emmet's, which leaves but little scar tissue. The operation described can be done more quickly than the tedious operation of Emmet, and when well done accomplishes the same purpose.

Many procedures have been brought forward for complete laceration of the perineum, but I am convinced that the operation described by Dr. Green is best of all. Good results have been obtained by the Simon-Heger, the Freund, the Hildebrandt, the Martin, the Emmet, the Tait, the Simpson, and other methods, but the great objection to each of these operations is that the women whose perinei have been operated upon by these methods, and have the appearance of being perfectly restored, are very liable to complain that they have no power of retaining the gaseous and liquid contents of the intestine. Whenever this complaint is made the operator will know that he failed to get a good union of the deep muscular planes and the divided ends of the sphincter ani muscle. Again, the union may be complete superficially, but "a cavity may be left more deeply with a resulting recto-vaginal fistula." Since more care has been taken to pass the sutures through the perineum entirely so as to bring the deeper parts in apposition, the recto-vaginal fistula has not been so frequent, but in the modified operation of Dr. Green this accident is guarded against in a very successful way.

According to his method "the ends of the torn sphincter are loosened up and secured with medium-sized catgut and two or three heavy silk approximating ligatures, taking a good hold on either side to relieve the tension on the parts." This procedure, combined with the American opera-

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

2. Once the problem is identified, the next step is to define the objectives and goals of the project. This helps to clarify what needs to be achieved and provides a clear direction for the team.

3. The third step is to develop a plan or strategy to address the problem. This involves breaking down the problem into smaller, manageable tasks and determining the resources needed to complete each task.

4. The fourth step is to implement the plan. This involves putting the strategy into action and monitoring progress to ensure that the project is on track.

5. The final step is to evaluate the results of the project. This involves assessing the outcomes against the objectives and goals and identifying any areas for improvement.

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5. Finally, the fifth step is to evaluate the results of the project. This involves comparing the actual outcomes against the objectives and goals to determine the effectiveness of the project.

1. The first of these is the fact that the United States has a large and growing population of people who are of Mexican descent. This population is concentrated in the southwestern United States, particularly in California, Arizona, and New Mexico. It is estimated that there are over 10 million people of Mexican descent in the United States, and this number is expected to increase significantly in the future.

[illegible]

There are three or four things that I want to add just a few more minutes to the end of the hour. I want to say a few words about the question of the importance of the individual in the movement. I want to emphasize the importance of a man who can take up a part of the burden of the world. I know that this is a hard thing to say, but I know that I have tried to. There are several other things in which, like all good Christians, I will not agree. All of us who do any work for the divine—the nurse, the doctor, the general surgery, the obstetrician, the divine where there have been excessive and excessive problems. In such cases as that the



bowel perhaps for inches has been destroyed, and you have instead of a healthy tube such a condition that it is impossible to bring down the bowel. In such cases as that I do not think even Dr. Green himself would apply this operation. I have tried it, however, in the better class of cases, and I know it works well.

I would differ from Dr. Green just a little with respect to his first division of, or classification of, tears in the perineum. It may not be any improvement. I scarcely think it is. Instead of cutting out the mucous membrane in the smaller form of tear, I would do Tait's perineum operation, that is slitting it up and converting a transverse incision into a longitudinal, and leaving the mucous membrane right open, not cutting it out, but leaving it there. You are bound to have union by first intention, as far as my experience goes, because you have no possibility of secretions falling into it.

While here I want to add a word in favor of the primary operation for laceration of the perineum. You know the rule is here, as well as everywhere else in surgery, to close the wound, if possible, and obtain primary union. The reasons have been well given already. If done promptly the results are justifiable. I know there are men here who have operated a hundred times to my one, and competent to operate much better, but so far as I am concerned I have never seen a failure after the primary operation. I saw one partial failure where I was not able to take the after-treatment myself, and it might have happened if I had been.

DR. J. W. STREETER of Chicago.—I would not say a word on this subject, were it not that I believe that it is quite an important one, and that so far as it is possible for us we should settle it in our own minds, and be consistent at least. It seems to me that we are too far advanced in surgical knowledge, in pathological knowledge, in our ideas of sepsis and antisepsis, to revert to the old method of allowing

nature to do the work which art can do a great deal better. The perineum should be sewn at once when it is torn. There is hardly an exception. I once used a common needle and linen thread, when I was too far away from silk and suitable instruments, and it was not a success. In every other instance in my experience, which has not been a very limited one, the primary operation has been successful. If successful, why not do it every time?

The lacerations of the cervix—the primary repair of these which is done in some of the German hospitals is a surgical exploit, and that is all there is of it. Nine-tenths of lacerations of the cervix will repair themselves so that the gynecologists will never find them. I can imagine a case, now and then, where it would be wise to take a few stitches. But ordinarily, as I said before, it is a surgical exploit which will never become general in private practice.

DR. J. C. WOOD of Ann Arbor.—As to a perineal operation, or an operation on the pelvic floor, I experimented for some time with the flap-split operation, and was delighted with it, so far as restoring the perineum was concerned. I found out, however, by experience that in those cases where there was decided relaxation of the pelvic floor with rectocele that it did not fulfill the indications, so that by degrees I simply extended the flap-split until I separated the tissues simply by the flap-split process to the crest of the rectocele, even if the crest was near the cervix uteri. Then, instead of dissecting out the tissue, I found by experiment that if the tissues were brought together underneath the superior flap that it accomplished the desired end; that it gave us a posterior pillar; that instead of being in the way, it was a most valuable supporting medium. If the perineum is to be restored, I make my outside incisions exactly as in the Tait flap-split method. If it is simply to overcome the relaxation of the pelvic floor, I make my incision high, or simply underneath the vaginal mucous membrane, make my dissection with the finger (and

the whole thing can be done in two or three minutes), and bring the underlying surfaces together with a continuous catgut suture passed through the vaginal mucous membrane, the sutures being entirely passed through the vagina. The result, I think, will be surprising to those of you who will experiment with this operation.

DR. GREEN closed the discussion as follows: There has been so much said upon the subject of immediate repair of laceration that it is hardly worth while for me to reply, but it is a subject to which we cannot give too much emphasis, and it is useless for a man to put his theories against another's experience, and when I hear a man condemning the immediate repair of a lacerated perineum I have but one thought in my mind, and that is that he is theoretical and not practical. When a man says he has repeatedly examined cases that have been operated upon and were faulty in their result, I must say it has not been properly done. I have seldom seen a failure, and I have been doing this ever since I began the practice of medicine. In my early operations it was not well done, and I failed probably in forty per cent. of my cases, but after studying over the causes of these failures they disappeared.

In regard to the rupture of the cervix, I believe the writer states that a rupture of the cervix often occurs at the same time, and why not repair it as well. I say, why not repair it as well?

I do repair it as well. Whenever I am called upon to operate on a lacerated perineum I always examine the cervix, and if the cervix has been lacerated I draw it down and repair it at the same time. We cannot neglect any of those things that will benefit a patient who is under our care.

In regard to the draw-string operation, I have operated a number of times with that. It is imperfect, does not give good results, and the reason is principally that it shortens the anterior vaginal wall, and destroys the parts that we attempt to restore.

I have also performed Tait's operation a number of times, and I find that faulty. The fault is in not removing the flap. A portion of the flap protruding into the vagina causes more or less deformity, and I have found better results by removing the flap than when I left it. Why should not the flap be removed? You have got to dissect these structures down to the muscular tissue. If you simply denude a part you will not get strong union. That structure is cicatricial. It is devoid of circulation, and why not remove it? How do you know that a nerve fiber may not be pinched in that scar? If you know anything about orificial surgery you know it may, and you know it is bad surgery to leave a scar tissue anywhere.

In respect to the subinvolution of the uterus, etc., the doctor is wrong in his anatomy. The parts have been overdistended. The blood vessels have lost their support. There has been exudation of matter there that has become organized, the parts are thickened, and the whole thing is the result of the want of support, which has been taken from the vagina.

In regard to the suggestion made by Dr. McDonald, I accept that.

The following question was asked of Dr. Green : How many hours may elapse before it is too late to sew up the peritoneum after labor ?

DR. GREEN.—That depends very much upon the accoucheur. If the man is one who is given to antiseptic methods the operation may be delayed for several hours ; but ordinarily if it is not done at once, if several hours elapse, the tissues become swollen and probably have been infected, and it will not do to sew the peritoneum up after the lapse of ten or twelve hours, as he is liable to have failure.

THE CHAIRMAN.—There is a little confusion in regard to the primary operation upon the cervix. Do you wish

the congress to understand that you operate upon a torn cervix at the time, or were you referring to a secondary operation? Do you repair the peritoneum at the time of the accident, and also the cervix at the time of the accident?

DR. GREEN.—When I am called upon to repair a lacerated peritoneum—an immediate repair, I mean—I always examine the cervix, and if I find a lacerated cervix, and it is my judgment that it can be mended, it is my habit to sew it then and there. Sometimes it will not unite, but often it does. Where the labor has been perfected and where the parts are greatly bruised and ecchymosed, it is probably not necessary to do it, as it will not unite; but in my experience a reasonable number of cases will unite, and save the patient a secondary operation for laceration of the cervix.

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## ● EDITOR'S TABLE. ●

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THE value of electricity in the treatment of disease in women is, we are glad to see, receiving more and more attention, and its use is being elevated into a position of assured success. The electrical force is so akin to vital force in its nature that it has only to be studied in the true scientific spirit to be developed into a therapeutic agent of vast potentiality. This indeed it is now, and we may reasonably hope that within the next few years our knowledge of its value in gynecological work will be greatly extended.

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AT the recent meeting in Chicago of the American Electro-Therapeutic Association Dr. A. Laphorn Smith of Montreal read a paper on the treatment of dysmenorrhea by the galvanic current, in which he took the ground that dysmenorrhea is very commonly due to endometritis rather than to stenosis of the canal. Thus many cases are not at all relieved by rapid dila-

tation of the canal unless this procedure is followed by curetting or the application of iodine. From theoretical considerations he had been inclined to believe at first that the method of intra-uterine galvanization which he advocated for the relief of dysmenorrhea would result in sterility, but further experience has shown this not to be true. Apostoli quotes thirty cases in which pregnancy followed such applications. This important theoretical objection being disposed of, he felt free to urge the adoption of this treatment, as the mild currents employed rendered it both safe and painless. If the uterus be large, and the menstrual flow profuse, he would use the positive pole in the uterus; but if the uterus were poorly developed, and the flow scanty, then he would prefer the negative pole.

After a careful bimanual examination has excluded pregnancy, and has enabled the operator to form a correct idea of the condition of the pelvic organs, the vagina should be disinfected with a douche, and a large Simpson sound, curved to correspond with that of the uterine canal, is passed through the flame of an alcohol lamp, cooled and insulated with rubber tubing to within about  $2\frac{1}{2}$  inches of its tip. Under the guidance of the finger it is then gently passed into the canal until an obstruction is met with, when a current of about 10 ma. is turned on. The instrument soon passes on, and after a current of from 20 to 50 ma. has been allowed to flow for about five minutes, it is gradually reduced and turned off. The sound will then usually almost drop out of itself. A boroglyceride tampon is then inserted in the vagina, and the patient allowed to go home. No precautions, such as resting in bed, are considered necessary, and, as a rule, the patient only receives the treatment twice a week for from three to six weeks, when the second period will usually come on without pain. When the intra-uterine electrode is connected with the negative pole, the positive pole consists of a clay abdominal electrode. Where the positive pole is made the active one, this pole must be of platinum, carbon, or zinc.

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IN the discussion of Dr. Lapthorn Smith's paper Dr. Massey said he could indorse all that the author had said about the simplicity and safety of this treatment. He rarely saw atresia

except after the use of very strong currents, or where the operator had neglected to insulate the cervical portion of the electrode. For this purpose he preferred shellac to a rubber tube.

Dr. W. B. Sprague of Detroit said he had very rarely failed to relieve dysmenorrhea by intra-uterine application of electricity. He preferred to use the negative pole with a current of moderate strength, and so far from producing atresia, he had relieved such as already existed. In this class of cases he never used currents stronger than 15 ma., and he was inclined to believe that the menstrual pain is due to hypersensitiveness of the nerves rather than to endometritis; for he had relieved the condition by currents so mild that they could hardly be expected to cure an endometritis.

Dr. P. S. Hayes of Chicago said he wished to be placed on record as fully indorsing the claims made in the paper.

Dr. Margaret A. Cleaves of New York said that after an experience of six or seven years she could corroborate what had been said in the paper. She thought the dysmenorrhea was quite as often due to pelvic congestion as to endometritis, and that this explained why it was relieved by such mild currents. A number of her patients had become pregnant within a few months, and she did not believe that intra-uterine galvanization caused sterility after the treatment. She greatly preferred leaving an interval of from five to seven days between the treatments.

Dr. J. H. Kellogg had found that although there was no stenosis of the canal, many cases of dysmenorrhea are associated with vegetations which he believes swell up at the menstrual period, and so produce a temporary obstruction. At any rate, such cases readily yield to applications of 10 to 20 ma., usually with the positive pole in the uterus. Where the trouble seems to be due to simple hyperæsthesia, he had found the positive pole especially effective. His experience was entirely opposed to the idea that the treatment prevented pregnancy.

Dr. C. R. Dickson believed with Dr. Cleaves that dysmenorrhea is very frequently due to simple pelvic congestion. He was glad to see that operating surgeons were showing a greater disposition than formerly to refer these cases to those who make a specialty of electro-therapeutics.

Dr. Franklin H. Martin sounded a note of warning against recommending such intra-uterine treatment too freely to the general profession. The initial step should be the making of an accurate diagnosis. If the dysmenorrhea were due to non-development of the uterus, the faradic current of slow vibration would be much more appropriate than the galvanic; if, on the other hand, it were due to tubal or ovarian disease, the galvanic treatment would result disastrously. Where dysmenorrhea is due to endometritis or stenosis of the canal, positive galvanism to the interior of the body of the uterus only was indicated.

Dr. Walker said that when the pain was most marked—two or three days previous to the appearance of the flow—he was always very suspicious of the existence of disease of the appendages, and therefore would not resort to galvanic treatment until a careful examination, under chloroform, had excluded such a condition.

Dr. Smith, in closing the discussion, said that he had taken it for granted that an accurate diagnosis was a prerequisite to safe and successful treatment. Believing as he did that in the majority of cases dysmenorrhea is due to reflex spasm of the fibers of the internal os, brought about by an endometritis, he preferred to apply a mild current *directly* to the internal os.

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THERE was also a very interesting discussion on the possibilities of electricity in the treatment of fibroid growths. Dr. J. H. Kellogg opened the discussion. He said that the improvement in the general health observed was due to the influence of the electric current on the abdominal sympathetic. The growth could be arrested, and in certain cases near the menopause retrograde changes could be effected. He had on a former occasion reported a series of fifty cases, in seven of which the tumor disappeared. Since then he had not been quite so fortunate. No one would think of employing anything but the constant current except for the relief of pain. He usually employed a coulombmeter in conjunction with the milliamperemeter, thus avoiding troublesome calculations. His personal experience had led him to think that the phlebitis sometimes excited where very powerful currents are employed is a decided help in bringing about retrograde changes in the tumor. He would not employ



this treatment in rapidly growing tumors unaccompanied by hemorrhage, in rapidly growing tumors appearing after the menopause, where ovarian cysts accompany the fibroid tumor, where the application is followed by inflammation, and in cases which do not show improvement after a reasonable trial. Recently he had been employing milder currents because they caused less inconvenience, and admitted of more frequent applications. Seventy-five per cent. of his cases had been symptomatically cured, in fifty-five per cent. the tumor had been very much reduced, and in fourteen per cent. it had entirely disappeared.

Dr. Felice La Torre of Rome, Italy, sent a contribution to the discussion. The galvanic current, in his opinion, certainly arrests hemorrhage, but the diminution in size of the tumor was rare. He discussed a number of theories as to the action of the current, and concluded that it acts chiefly in two ways, viz.: (1) by causing energetic contraction of the uterus, and in this way causing compression of its vessels and arrest of hemorrhage; (2) by producing a disturbance in the molecular interchange of the elements of the tumor, by which the nutritive juices are transformed into peptones or other substances which are absorbed or eliminated by the kidneys, thus giving rise to absorption of the fibroma.

Dr. A. Lapthorn Smith had found that this treatment arrests hemorrhage, even in very desperate cases, and the general health is at the same time improved. In about half of his cases there was arrest of growth, and in about half of these the tumor had diminished in size. In only one case was he sure that the tumor had entirely disappeared. The treatment is contra-indicated when there is reason to believe there is pus in the tubes. He favored the use of mild currents, and the sittings not oftener than twice a week. He had never given in any one case of this kind more than one hundred applications, and he usually observed marked improvement after about fifteen applications.

Dr. Margaret Cleaves said that she had found the treatment of especial value in intra-mural growths, and that in this class of tumors the pressure symptoms were invariably relieved, the general health improved, and in hemorrhagic cases there was an arrest of the hemorrhage. In a limited number of cases there was some

anatomical retrogression, but in no instance had she observed a complete disappearance of the tumor. She believed that the arrest of the hemorrhage was as largely due to the cataphoric action of the current as to the chemical cauterization. She called attention to the experiments made by Mr. Stewart of Owen's College Laboratory, by which he had demonstrated the increase of liquids at the negative pole and also an accumulation of salts at the positive pole. In order that there should be such an accumulation it was necessary that first there should be a decomposition and redistribution of the salts. Fibroid tumors and inflammatory products are rich in salts, especially in chloride of sodium, and are very largely dependent upon the presence of these for the maintenance of their nutrition and growth. The experiments to which she referred go to show that the removal of a considerable proportion of the salts, even if that removal were temporary, would result in the destruction of the tissue, while the removal of a small proportion would affect its nutritive activity. She had also found the induced and static induced currents of very great value as an adjuvant in the treatment of fibroid growths by means of the constant current. Cases in which the static induced had been used noted a marked sense of well-being, buoyancy, and lightness, not only in the pelvis, but in the entire abdominal region.

Dr. Massey said that in a series of 80 cases, in all of the 34 hemorrhagic ones the hemorrhage was controlled, in 10 the growth was simply arrested, in 49 there was distinct retrogression, and in 7 the tumor disappeared. The average current strength was 50 to 150 ma., and the duration of active treatment varied from six weeks to three months.

Dr. Engleman had had much the same experience as the other speakers. He did not doubt that the tumors could be reduced in size provided they were placed under treatment at the proper time; but he was also compelled to admit that he had seen some very large tumors disappear without any treatment, and this had been the experience of other surgeons. We should be very careful not to employ electrical treatment if there is reason to suspect that the tumor has already begun to undergo malignant metamorphosis, for under such circumstances electricity will certainly aggravate the condition.

Dr. A. H. Goelet said that one of the principal uses of electricity, in some cases of large tumors, is to improve the general health of the patient when it is so much deteriorated as to admit of operative procedures when they are demanded. He had observed considerable retrogression in favorable cases, but had never seen a complete disappearance of the tumor. It was almost always possible to effect a symptomatic cure. He preferred strong currents and short sittings, and did not think much could be accomplished in less than six months. In recent growths, and in myomata, he would expect retrogression. He advocated the use of the positive pole in myomas and where hemorrhage was a symptom, and the negative pole in fibromas. He called special attention to the danger of producing stenosis even with negative applications of only 50 ma. when the cervical canal is included in the action exerted by the current.

Dr. Hayes thought a useful adjuvant to the ordinary Apostoli treatment consisted in applying the static induced current by means of abdominal and vaginal electrodes.

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DR. J. H. KELLOGG of Battle Creek read a fine paper on the graphic study of electrical currents in relation to therapeutics. He said that he thought thus far in the discussion two or three different forms of current had been confounded, for the rapidly interrupted current is not a sinusoidal current. He first described this current in a paper read before the American Medical Association in 1888. The effects obtained from it varied with the speed of the machine. When only fifteen or twenty alternations were made per second, it produced vigorous muscular contractions with complete relaxation at each alternation. The sensory effects are best obtained by giving the machine a high velocity; under such circumstances it will be found that if the electrode be placed in the region of the eye, the subject will perceive a luminous field which varies its position with that of the electrode.

He had made more than twenty thousand applications of the sinusoidal current, the greater number being in gynecological cases, and with it he had been enabled to cure hundreds of women who had previously suffered many things at the hands of gynecol-

ogists. The current is chiefly useful : (1) In exercising muscles which are not easily brought into action by voluntary effort ; (2) for producing muscular contraction in cases where degenerative changes have advanced so far that the muscles fail to respond to the faradic current ; (3) in connection with " the rest cure " for giving exercise to feeble patients. Here it is superior to the faradic current on account of the painlessness of the contractions and their greater vigor. The application is also more easily made, as it is not necessary in most cases to locate accurately the motor points. (4) It is very valuable when used alternately with massage. (5) It is of the greatest advantage in strengthening relaxed abdominal muscles, which are often responsible for displacements of various abdominal viscera, and the occurrence of various reflex symptoms. (6) For the treatment of hyperæsthetic conditions of the nervous system. Here it is necessary to employ an extremely delicate rheostat, and to use the current obtained from the machine while at a high speed. In marked contrast with the faradic current, he had found no idiosyncrasy to the sinusoidal current.

He believed the rheotome was a fatal element of weakness in the induction coil, and that this well-known instrument is inherently faulty as an agent in electro-therapeutics. Nothing but the graphic method would enable the medical practitioner to regulate a faradic apparatus so as to obtain exactly the same current at all times, and he predicted that the faradic apparatus would have to give place to a more reliable instrument.

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#### NOTES ON CURRENT LITERATURE.

DR. CHARLES L. DANA, who has had wide experience as a neurologist, has published a work on nervous diseases which will prove of great service to general practitioners of medicine, and will serve as a text-book for students.<sup>1</sup> Although concise in form, it is quite complete in covering a general description of the neuralgic system and its diseases. It is well arranged for reference, the classification being most excellent. Besides covering the degenerations, sclerosis, and atrophies of the brain and spinal chord, it also gives the neuroses and other disorders of the nervous system, such as insomnia, catalepsy, and nightmare.

<sup>1</sup> TEXT-BOOK OF NERVOUS DISEASES—Being a Compendium for the use of Students and Practitioners of Medicine. By CHARLES L. DANA, A. M., M. D. With 210 illustrations. New York : Wm. Wood & Co., 1892.

The work is very fully illustrated, and the illustrations are excellent and characteristic. Neurologia is a difficult branch of medicine to master, and yet is comparatively easy if its study is undertaken in a proper and systematic way. An opportunity for such study is presented with real good judgment in this book, which is small enough to be truly a handbook, and yet covers all the conditions which are likely to come within the observation of the general practitioner. Those nervous diseases which he is likely to meet with, and which it is extremely important he should be able to diagnose with celerity and precision, are here presented in such a shape that he can easily make them a part of his working knowledge.

BRAIN SURGERY is a novel and interesting department in general surgery. It is now only a few years since it was considered possible to operate upon the brain for the relief of epilepsy and of imbecility, for the relief of clots from the brain, for the opening of abscesses, for the excision of tumors, and for the relief of intercranial pressure, yet it is now admitted that in the hands of careful and experienced surgeons such operations may be performed with considerable hope of successful relief to the patient. This class of work is so new that it can hardly yet be stated what the possibilities of permanent success may be, though there is no doubt that in the technical sense the operation may be performed successfully—that is to say, the patient recovers from the shock of the operation. Whether he is really benefited by that operation is another question, though there seems to be a reasonable hope that this form of surgery may prove of great benefit when it comes to be studied as thoroughly as abdominal surgery has been.

One of the best authorities on the subject of brain surgery is Professor M. Allen Starr of the medical department of Columbia College. Professor Starr gives in his "Brain Surgery"<sup>1</sup> all that is now known on the subject, which is a very interesting one, not only to surgeons but to the general practitioner. Even although one may not use this information in a practical way, the work will prove of value to the general practitioner and to the specialist in another department of medicine as throwing considerable light upon the functions of the brain, especially when it is in a pathological state. It certainly opens up many interesting questions. The work is well illustrated and beautifully printed, and certainly deserves a place in the library of every general practitioner.

THE subject of mental disturbances is one which interests every physician. In nearly all diseases, both acute and chronic, the mind is more or less disturbed, and we as homeopaths realize how important are the subjective mental symptoms in the

<sup>1</sup> BRAIN SURGERY. By M. ALLEN STARR, M. D., Ph. D. with fifty-nine illustrations. New York : Wm. Wood & Co., 1893.

treatment of all cases. Professor Theodore Kirchhoff of the University of Kiel has prepared a handbook of insanity which covers all the various grades of mental disorder, and will be found of use to the general practitioner not only as a refresher of his memory, but as giving the latest information on the anatomy and physiology of insanity, and other diseases of the brain.<sup>3</sup> Of special value to the general practitioner are the chapters on hallucinations and illusions, as these are conditions often met with as complicating acute diseases. Ready familiarity with the earliest symptoms of dementia, melancholia, and mania will enable the skillful homeopathist to stay the retrograde process and in many cases perform a cure. There is no doubt in the minds of those who have given special attention to the value of homeopathic medication in the earliest stages of brain disorder as to its mighty influence in staying retrograde changes. There can be no doubt that nearly all of these cases could be cured if taken in the earliest stage and treated on the Hahnemannian Law. It is therefore of great importance that all physicians should understand the meaning of these symptoms and be able to meet them promptly and successfully. Dr. Kirchhoff's work is well written, and will serve the purpose here indicated probably better than any other recent work, and we commend it to our readers as authoritative, and therefore valuable.

THE centennial period in American history, which began nearly twenty years ago, and has culminated now in the Columbian Exposition, has produced as one of its fruitions a series of local histories, especially of towns in the Eastern States and along the Atlantic seaboard. Among the most valuable of these is a memorial history of the city of New York, edited by General James Grant Wilson, and consisting of four large quarto volumes handsomely illustrated both with plates and with illustrations in the text.<sup>4</sup> The choice of General Wilson as an historian of the city of New York was an exceedingly wise one; probably no one is better fitted for this office than he, and everyone who simply glances through these magnificent volumes will see how much of personal affection for the city he has wrought into these broad pages. The purpose of this history was to present a vivid picture of life in New York from the time of the arrival of the first European down to the present day, and this has been done with a

<sup>3</sup> HANDBOOK OF INSANITY, FOR PRACTITIONERS AND STUDENTS. By THEODORE KIRCHHOFF, M. D. Illustrated with eleven plates. New York: Wm. Wood & Co., 1893.

<sup>4</sup> THE MEMORIAL HISTORY OF THE CITY OF NEW YORK, From its First Settlement to the year 1892. Edited by JAMES GRANT WILSON. In four volumes, profusely illustrated. New York: N. Y. History Co., 132 Nassau Street. Price \$30 for the set.

fullness of treatment and a wealth of illustration which are almost marvelous. Like most works of this sort, the authorship is composite, General Wilson having called to his aid many well-known writers, including descendants from the earlier settlers, who had special opportunities for securing proof and authentic material which had never before been presented to the public. In this way the volumes have become not merely really representative of what was already known, but a repository of much material of great interest and value, which had never before been made accessible. Among those who have thus aided in making the work what it is might be mentioned Rev. Dr. Vermilye, James W. Gerard, Rev. Dr. Da Costa, Wm. L. Stone, Charles Burr Todd, John Austin Stevens, and Robert Ludlow Fowler. Each volume contains a number of steel engraved portraits of noted New Yorkers, such as John Jay, Peter Stuyvesant, George Clinton, and Rufus King, besides an almost innumerable number of woodcut portraits printed in the text. The illustrations, which include maps and plans, autographs, facsimiles of letters and public documents, amount to hundreds; as for the typographical body of the work, it need only be said that it is from the press of Theodore De Vinne, whose superior workmanship is evidenced in the *Century*, and who is probably the best printer in this country.

THAT valuable compend of medical knowledge edited by Dr. Sajous, which has now appeared so many years as to seem like a permanent arrangement, has appeared for 1893, rather late in the day, but still very good now that it has come.\* We have spoken in such strong terms of commendation of this work in previous years that there would seem to be no new adjective in which to express our admiration of the ingenuity and assiduity of the editor and his able assistants. The editorial staff is certainly the strongest that has ever been brought together in any medical work. The associate and corresponding editors number nearly three hundred, and these include very many of the best known practitioners in the world. Like their predecessors, this noble series of volumes of '92 contains all that is new and valuable, here brought together by such shrewd arrangement and condensations that one can find in a moment whatever has been written on any subject in medicine. The volumes are fully illustrated, handsomely printed and neatly bound, and are certainly a most desirable addition to any physician's library.

\* ANNUAL OF THE UNIVERSAL MEDICAL SCIENCES. A yearly report of the progress of the general sanitary sciences throughout the world. Edited by CHARLES E. SAJOUS, M. D., and seventy associate editors, assisted by over two hundred corresponding editors, collaborators, and correspondents. Five volumes. 1893. The F. A. Davis Co., publishers, Philadelphia, New York, Chicago and London. Australian agency, Melbourne, Victoria.

DR. GEORGE M. GOULD, already well known as the editor of two small medical dictionaries, has now about ready an unabridged, exhaustive work of the same class, upon which he and a corps of able assistants have been uninterruptedly engaged for several years. The feature that will attract immediate attention is the large number of fine illustrations that have been included, many of which—as, for instance, the series of over fifty of the bacteria—have been drawn and engraved especially for the work. Every scientifically minded physician will also be glad to have defined several thousand commonly used terms in biology, chemistry, etc. The chief point, however, upon which the editor relies for the success of his book is the unique epitomization of old and new knowledge. It contains a far larger number of words than any other one-volume medical lexicon. It is a new book, not a revision of the older volume. The pronunciation, etymology, definition, illustration, and logical groupings of each word are given. There has never been such a gathering of new words from the living literature of the day. It is especially rich in tabular matter, a method of presentation that focuses, as it were, a whole subject so as to be understood at a glance. The latest method of spelling certain terms, as adopted by various scientific bodies and authorities, have all been included, as well as those words classed as obsolete by some editors, but still used largely in the literature of to-day, and the omission of which in any work aiming to be complete would make it unreliable as an exhaustive work of reference. The publishers announce that, notwithstanding the large outlay necessary to its production on such an elaborate plan, the price will be no higher than that of the usual medical text-book.

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#### A CORRECTION.

DEAR DR. WINTERBURN :

Will you kindly correct a singular error in your account of the discussion on antiseptics by the obstetric section of the World's Homeopathic Congress? On page 467 a paragraph is credited to me which did form the closing portion of Dr. Richter's remarks, the word "speaker" being changed to *essayist* or an equivalent term. I distinctly remember that that gentleman vigorously criticised my paper in about those terms, and naturally was alike surprised and amused to find his words placed in my own mouth, which remained shut during the entire discussion save when briefly replying to one or two questions perhaps. I never could have claimed that the climate of Rhode Island is obnoxious to microbes, or have uttered the first sentence in my closing remarks (page 469), except in reply to a vigorous direct attack.

Very respectfully yours,  
GEO. B. PECK, M. D.



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